

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44375
State File No.
Registrar's No. **11870**

FILED JAN 5th 1954

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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|---|----------------------------------|--|---|--|---|---|----------------------------------|-------------------------|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri. b. COUNTY | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS, MISSOURI | | c. LENGTH OF STAY (In this place) | c. CITY OR TOWN St. Louis, | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL | | | e. STREET ADDRESS (If rural, give location) 3658 Fairview Ave. | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) Lucinda c. (Last) MEDLEY | | | 4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 15, 1953 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH March, 22, 1890. | 9. AGE (In years last birthday) 63. | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRs. Hours | IF UNDER 1 HRs. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At. Home. | | 11. BIRTHPLACE (City and State or Foreign Country) Bonne Terre, Missouri. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13a. FATHER'S NAME George Kelley | | 13b. MOTHER'S MAIDEN NAME Mary Louise Aubuchon | | 14. NAME OF HUSBAND OR WIFE Robert Medley. | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil. | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mabel Brothers, 3658 Fairview (Daughter) | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary artery arteriosclerosis DUE TO (c) Sclerolyzed arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 4201 | | | | |
| 22. I hereby certify that I attended the deceased from 12-12-53 , 19___, to 12-15-53 , 19___, that I last saw the deceased alive on 12-15-53 , 19___, and that death occurred at 12:35A m., from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Stanley A. Harris M.D. | | | 23b. ADDRESS 1515 Lafayette Avenue | | | 23c. DATE SIGNED 12-15-53 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE 12-17-53 | 24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens | | 24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo. | | | |
| DATE REC'D BY LOCAL REG. DEC 16 1953 | | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington. | | | | |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John S. Lennell*.....
Licensed Embalmer No. *4194*.....
P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.