

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9937
2895

State File No.

FILED APR 6 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

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|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE | | b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN | | c. LENGTH OF STAY (In this place) | | c. CITY OR TOWN | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | e. STREET ADDRESS (If rural, give location) | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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|-------------------------------------|------------|-------------|-----------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) | b. (Middle) | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
| ALICE | BECKER | CLAPPER. | March 30, 1954. | |

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|---------|------------------|--|------------------|---------------------------------|----------------------------|--------------------------|---------------------------|---------------------------|
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 1 YEAR Days | 12. IF UNDER 1 HRS. Hours | 13. IF UNDER 1 MIN. Mins. |
| Female. | White. | Widowed. | May 15, 1886. | 67. | | | | |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) | 12. CITIZEN OF WHAT COUNTRY? |
| At Home. | Housewife. | St. Louis, Missouri. | U.S.A. |

| | | |
|--------------------|---------------------------|-----------------------------|
| 13a. FATHER'S NAME | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE |
| William Becker. | Elizabeth Mathews. | Dr William L. Clapper. |

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|--|-------------------------|-----------------------------------|-----------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME | ADDRESS |
| NO. | none. | Elizabeth Clapper, | 9103 West Pine. |

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|--|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction | | DUE TO (b) Advanced arterio sclerosis | | 3-23-59 |
| *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | DUE TO (c) Chronic myocarditis post coronary | | 3 years |
| II. OTHER SIGNIFICANT CONDITIONS Cholelithiasis. Mitral regurgitation + stenosis | | | | |

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|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|--|

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|--|--|---|
| 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) |
| No | | 420.1 |

| | | |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from Jan. 1938, to March 30, 1954, that I last saw the deceased alive on 3-29-54, 19____, and that death occurred at 7:10 A. m., from the causes and on the date stated above.

| | | |
|----------------------------------|-----------------------------------|------------------|
| 23a. SIGNATURE (Degree or title) | 23b. ADDRESS | 23c. DATE SIGNED |
| <i>J. Fred W. Clark</i> M.D. | 809 Hamilton Blvd St. Louis 12 Mo | 3-30-59 |

| | | | |
|---|-----------|------------------------------------|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
| Cremation. | 3/31/54. | Valhalla Crematory. | #7600 St. Charles Rock Road. |

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|--------------------------|-------------------------|----------------------------------|---------------------|
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
| MAR 30 1954 | <i>J. Fred W. Clark</i> | C. R. Lupton & Sons, | #7233 Delmar Bly'd. |

(Licensed Embalmer's Statement on Reverse Side)

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 *Clarence A. Murray*.....

Licensed Embalmer No. *401*.....

P. O. Address *St. Louis*.....

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.