

No. 300
10.48

FILED JUL 28 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25424**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6427**

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4739 Natural Bridge Rd.		d. STREET ADDRESS (If rural, give location) 25 1205 No. 7th St., Apt. D.	

3. NAME OF DECEASED a. (First) Clayton (Type or Print)			b. (Middle) A.			c. (Last) White			4. DATE OF DEATH (Month) (Day) (Year) July 14, 1954			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 12, 1886			9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months Days	IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Venetian Blind Hanger-Wehmueller Co.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Elkland, Penn.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME Ely White		13b. MOTHER'S MAIDEN NAME Ella MacPherson		14. NAME OF HUSBAND OR WIFE Elease White	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Elease White, 1205 No. 7th St. Dpt.		ADDRESS	
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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						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)							
		ANTECEDENT CAUSES							
		DUE TO (b) Coronary Occlusion							
		DUE TO (c) Coronary Sclerosis							
		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 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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4201	
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22. I hereby certify that I attended the deceased from _____ 19____ to _____, 19____, that I last saw the deceased alive on _____ 19____, and that death occurred at **10:55 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Patricia Taylor Corcoran		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 7.15.54	
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24a. BURIAL, CREMATION REMOVAL (Specify)		24b. DATE 7/17/54		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Miss-ouri	
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DATE REC'D BY LOCAL REG. AUG 15 1954		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE PROVOST UND. CO., 3710 No. Grand Bl.		ADDRESS	
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WRITE PLAINLY—USING UNFAADING 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
Student Embalmer

Signed *Stanley H. Dipow* _____

Licensed Embalmer No. *4193* _____

P. O. Address *St. L.* _____

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 this body is not embalmed, fact should be so stated above.