

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30692

State File No.

FILED OCT 3 - 1955

Registrar's No. 8075

BIRTH NO. 68966-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St Louis	
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 Overland Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		d. STREET ADDRESS (If rural, give location) 9820 Reble Avenue	
3. NAME OF DECEASED (Type or Print) a. (First) Clarkson		c. (Last) Clarkson	
b. (Middle)		4. DATE OF DEATH (Month) (Day) (Year) August 25 1955	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH August 22 1955
9. AGE (In years last birthday)		10. MONTHS	11. DAYS
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) St Louis Missouri
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Henry Arthur Clarkson	
13b. MOTHER'S MAIDEN NAME Martha Everlena Trigg		14. NAME OF HUSBAND OR WIFE	
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 Martha Everlena Clarkson		ADDRESS Above	
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) Atelectasis - pneumonia	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Prematurity	
DUE TO (c)		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"/>		762.5	
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)	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 August 22, 1955 , to August 25, 1955 , that I last saw the deceased alive on August 25, 1955 and that death occurred at 10:25 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Robert C. Schaan MD		23b. ADDRESS St. L. Children's Hosp	
23c. DATE SIGNED 8/30/55		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 9-30-55	24c. NAME OF CEMETERY OR CREMATORY Anatomical Boro	
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith MD		
DATE REC'D BY LOCAL REG. SEP 14 1955	REGISTRAR'S SIGNATURE Carl Smith MD	ADDRESS Rowland Ave 4404 Mendenhall	

(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
Student Embalmer

Signed.....

Licensed Embalmer No.....

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