

FILED JAN 6 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

41916

10770

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. ....		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give town): <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis, Mo.</b>		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 <b>ST. LOUIS CITY HOSPITAL #1.</b>				6. STREET ADDRESS (If rural, give location) <b>5252 Maffitt.</b> <span style="float: right;">2069</span>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>WILLIAM</b> b. (Middle) <b>H.</b> c. (Last) <b>CLISE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>DECEMBER 6, 1955</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>July 12, 1875</b>		9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Sedalia, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		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) <b>NO</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>C. R. White</b> 123 S Queen York Pa.				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia, confluent, bilateral.</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>gangrene of left foot</b> DUE TO (c) <b>arteriosclerosis + diabetes mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10-15-55</b>	
19a. DATE OF OPERATION <b>11-8-55</b>		19b. MAJOR FINDINGS OF OPERATION <b>gangrene toe - (amputation of) 450-1</b>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <b>10-15</b> , 19 <b>55</b> , to <b>12-6</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>12-6-</b> , 19 <b>55</b> , and that death occurred at <b>10:55</b> a.m., from the causes and on the date stated above.								
23a. SIGNATURE <b>Alan S. Wertz MD</b>				23b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		23c. DATE SIGNED <b>12-6-55.</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>Dec. 9, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Co.</b>			
DATE REC'D BY LOCAL REG. <b>DEC 8 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Quinn</b> ADDRESS <b>1389 Union Blv'd.</b>			
(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 *Ronald O. Yahn*.....

Licensed Embalmer No. *39*.....

P. O. Address *Haw*.....

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.