

FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003 STATE FILE NUMBER

6072

Registration District No. 318 Primary Registration District No. 812 Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <del>St. Louis</del>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6050 Kingsbury Bld.</b>		Length of stay in lb <b>75 years</b>	STREET ADDRESS (If outside, give location) <b>6050 Kingsbury Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>T</b> Last <b>Clinton</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>24th.</b> Year <b>1957</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8th. 1869</b>	9. AGE (In years last birthday) <b>87</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House-wife</b>	11. BIRTHPLACE (City and state or country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Michael Dwyer</b>			14. MOTHER'S MAIDEN NAME <b>Margaret O'Brien</b>		
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. <b>no</b>	17. INFORMANT Address <b>Walter S. Clinton 6050 Kingsbury Blvd.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) <b>Arterio Sclerosis - Eccentric</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>422.1</b>		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>1930</b> to <b>Jan 24-57</b> and last saw her/him alive on <b>Jan 24-57</b> . Death occurred at <b>7.30 P. m</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Walter S. Clinton M.D.</b>			22b. ADDRESS <b>Clinton Bldg</b>		22c. DATE SIGNED <b>1-25-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>1-26-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Arthur J. Donnelly 3840 Lindell Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 25 '57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	

(Licensed Embalmer's Statement on Reverse Side)

300  
-56

Disease in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature where it is used. No symptoms which be listed. AN

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. A. J. Sealbold  
Carleton College  
12-2

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 me....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Wm. Sealbold.....

Licensed Embalmer No. 3840

P. O. Address 3840

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.