FILED FEB 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 6942

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 157

1. PLACE OF DEATH
a. COUNTY: St. Louis County
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kirkwood — Inside Limits Yes ✓ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: White Oaks — Length of stay in Ib: 2 1/2 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY:
c. CITY OR TOWN: Louisville — Inside Limits Yes ✓ No ☐
d. STREET ADDRESS (If outside, give location): Local — Reside on Farm Yes ☐ No ✓

3. NAME OF DECEASED (Type or print): First: Drallie Middle: Last: Tolliver
4. DATE OF DEATH: Month 1 Day 19 Year 57
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 9-10-88
9. AGE (In years last birthday): 68 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (City and state or country): -unk- Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John R. Clifton
14. MOTHER'S MAIDEN NAME: Rosalie Speak
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Leona Schaper — Address: Kirkwood Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): CEREBRAL HEMORRHAGE — 2 yrs + 2 mos
DUE TO (c): ARTERIOSCLEROSIS — many yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ✓
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from June 1957 to Jan 1957 and last saw her alive on Jan 12, 1957. Death occurred at 3:05 AM m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: [signature] (Degree or title) MD
22b. ADDRESS: 4500 W. Pine St Louis
22c. DATE SIGNED: 1-19-57
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: JAN. 21-1957
23c. NAME OF CEMETERY OR CREMATORY: ORCHARD HILL
23d. LOCATION (City, town, or county) (State): LOUISVILLE ILL.
24. FUNERAL DIRECTOR: Chas Burke ADDRESS: East St Louis, Ill
25. DATE RECD. BY LOCAL REG.: 1-19-57
26. REGISTRAR'S SIGNATURE: Herbert R. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Chas. M. Burke

Licensed Embalmer No. 24

P. O. Address E. St. Louis

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.