

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 18 1957

STATE FILE NUMBER 10058

318

1003

1949

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

Health,
& Welfare
Public
Service

300
1-56

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ark.</u> b. COUNTY <u>LITTLE ROCK</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>North Little Rock</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo Pacific Hosp</u>			Length of stay in lb <u>one 3d</u>		d. STREET ADDRESS <u>1415 Pine St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>WMM</u> Last <u>CLARK</u>				4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>57</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13 1892</u>		9. AGE (In years last birthday) <u>64</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RR laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>La. 0</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Clark</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>702-16-2733</u>		17. INFORMANT Address <u>Isabel Clark 1415 Pine</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myeloblastic leukemia</u> DUE TO (b) <u>months</u> DUE TO (c) <u>weeks.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 <u>one month</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u>a. m.</u> Month, Day, Year <u>p. m.</u>									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			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 <u>Jan 27-57</u> , to <u>Feb 25-57</u> and last saw <u>her</u> alive on <u>Feb 22-57</u> . Death occurred at <u>8:15 p. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
21a. SIGNATURE <u>Charles Krones M.D.</u> (Degree or title)				21b. ADDRESS <u>1756 S. Grand</u>			21c. DATE SIGNED <u>2/26/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2-26-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Haven Rest</u>			23d. LOCATION (City, town, or county) (State) <u>N. Little Rock, Ark.</u>		
24. FUNERAL DIRECTOR <u>Ellis Funeral Home, St. Louis</u>				ADDRESS <u>2820 Stoddard</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 26 1957</u>		26. REGISTRAR'S SIGNATURE <u>J. Paul Smith, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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, *Fulton E. Culter*

Licensed Embalmer No. *419*

P. O. Address *Free*

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.