

FILED SEP 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
33912
8682

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Oconee	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 32	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
CLARENCE OTTO MOUNT		SEPT. 13, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		11. BIRTHPLACE (City and state or country) Montgomery County, Ill.	
13a. FATHER'S NAME James Mount		14. NAME OF HUSBAND OR WIFE Ruth Mount	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. 359-01-2027	
17. INFORMANT Address Ruth Mount, Oconee, Illinois,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AGRANULOCYTOSIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 297x	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 TR.	
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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 AUG. 22, 1957 to SEPT. 13, 1957 and last saw her alive on SEPT. 13, 1957 Death occurred at 4:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Lawrence W. O'Connell M.D.	
22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 9/13/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-13-57	
23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Shelby County, Illinois	
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington,		25. DATE RECD. BY LOCAL REG. SEP 16 '57	
26. REGISTRAR'S SIGNATURE Carl Smith M.D.		26. REGISTRAR'S SIGNATURE mgs	

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

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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 *[Signature]* Licensed Embalmer No. *4405* P. O. Address *[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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.