

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008328

STATE FILE NUMBER

FILED MAR 12 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 660

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY OR TOWN <b>Affton</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Affton</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7059 DEERPATH</b>		Length of stay in lb <b>9 years</b>	d. STREET ADDRESS <b>7059 Deerpath Drive</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Alexander</b> Last <b>Claridge</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>2</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 31, 1886</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Momence, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Alexander Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Julia Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Ralph A. Claridge</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>NONE</b>	17. INFORMANT <b>Robert A. Claridge</b>		Address <b>8751 Kathy Court</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>coronary occlusion</b> <b>arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>4201</b> DUE TO (c) <b>approx 5 yrs.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT <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 <b>Aug '57</b> , to <b>3-2-58</b> and last saw her alive on <b>Aug '57</b> . Death occurred at <b>3: P</b> m on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE (Degree or title) <b>W. F. M. Gage, M.D.</b>			22b. ADDRESS <b>4952 Maryland</b>		22c. DATE SIGNED <b>3-2-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>Mar. 5, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>	23d. LOCATION (City, town, or county) <b>St. Louis</b>	23e. STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Hoffmeister Colonial Mortuary</b> <b>6464 Chippewa</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-4-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert P. Donker, M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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Health,  
Welfare  
Public  
Service

JUN 27 1962

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 *Bill C. Branson*

Licensed Embalmer No. *4764*  
P. O. Address *St. Louis, Mo.*

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.