

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015659
STATE FILE NUMBER

FILED APR 23 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4199

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4731a Vernon	
3. NAME OF DECEASED (Type or print) Charles (Charlie) Clover		4. DATE OF DEATH Month 4 Day 15 Year 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar, 6, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Troy, Mo
13a. FATHER'S NAME Willie Glover		13b. MOTHER'S MAIDEN NAME Sarah Wise	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 492-07-2573A	17. INFORMANT Address James Glover 1333A N. Euclid Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Hypertensive vascular disease DUE TO (b) Hypertensive vascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			INTERVAL BETWEEN ONSET AND DEATH undet.
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 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 4-4-58 to 4-15-58 and last saw ^{him} him alive on 4-15-58 Death occurred at 5:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Sydney A. Fraser (Degree or title) M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 4-16-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/19/58	
23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR ADDRESS Wright Funeral Home 3100 Easton Ave.		25. DATE RECD. BY LOCAL REG. APR 17 '58	
26. REGISTRAR'S SIGNATURE Carl Smith			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Arthur L. Hillier*

Licensed Embalmer No. *4221*
P. O. Address *3100 East*

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.