

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030463

STATE FILE NUMBER

8151

FILED SEP 8 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>15 LUTHERAN Hosp.</u>		Length of stay in lb <u>0</u>		d. STREET ADDRESS (If outside, give location) <u>4115 S. GRAND</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA A. HAD</u>			4. DATE OF DEATH Month Day Year <u>AUG. 20 1958</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 9 1885</u>		9. AGE (In years last birthday) <u>73</u>	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) <u>RETIRED SECRETARIAL WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post-Office</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>JOSEPH HAD</u>		13b. MOTHER'S MAIDEN NAME <u>FRANCES KOMEROUS</u>		14. NAME OF HUSBAND OR WIFE <u>LALLA PARTNEY 3525² DELOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give for unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>LALLA PARTNEY 3525² DELOR</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>Lymphatic leukemia chronic</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Aug 1958</u> <u>3 mo.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <u>204.0</u>							
DUE TO (c)							
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 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 <u>May 1956</u> to <u>8/20/58</u> and last saw her alive on <u>8/20/58</u> Death occurred at <u>11:00 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Edward W. Czobur, M.D.</u>			22b. ADDRESS <u>3701 Emerald St</u>		22c. DATE SIGNED <u>8/21/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG. 23 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S.S. PETER & PAUL</u>		23d. LOCATION (City, town, or county) <u>ST. LOUIS Mo</u>			
24. FUNERAL DIRECTOR <u>Thomas Kute 2906 Francis</u>			25. DATE RECD. BY LOCAL REG. <u>AUG 21 1958</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dec 30 1930
1-40309
Rural

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 *James C. Hill*

Licensed Embalmer No. *4347*
P. O. Address *2906 Harv*

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.