Health, & Welfare Public Service

11 4 S.300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-031318
STATE FILE NUMBER

FILED SEP 15 1958 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2344

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Brentwood — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Gould Worth Home — Length of stay in 1b 7 Months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Berkeley 404 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 6637 Torlina — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First MINNIE Middle R. Last CLARK
4. DATE OF DEATH Month Sep. Day 10 Year 1958

5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH Nov. 1, 1875
9. AGE (In years last birthday) 82 — 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) Housework
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and state or country) Astoria, Ill. 1
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William T. Foster
13b. MOTHER'S MAIDEN NAME Frances Derry
14. NAME OF HUSBAND OR WIFE Late McDonald Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT William W. Clark Address 6637 Torlina

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac dilatation — INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic myocarditis — 4 yrs
DUE TO (c) 422.2
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 ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 6-1-58, to 9-10-58 and last saw her alive on 9/3/58
Death occurred at 7 30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] 0
22b. ADDRESS Kirkwood N. Mo
22c. DATE SIGNED 9/10/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Mtr)
23b. DATE 9-11-1958
23c. NAME OF CEMETERY OR CREMATORY LOCAL
23d. LOCATION (City, town, or county) (State) Astoria, Ill.

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kingshighway
25. DATE RECD. BY LOCAL REG. 9-11-58
26. REGISTRAR'S SIGNATURE Herbert R. Domke M.D.

(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

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 Richard W. Stoessner

Licensed Embalmer No. 4007

P. O. 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.