Health, Welfare Public Service

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Pay aff. fun. director #3 1/16/59

FILED JAN 28 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002821
STATE FILE NUMBER

Registration District No. ..... Primary Registration District No. ..... Registr. No. 2 408

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS, MO. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LOUIS CITY HOSP. #1. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 2257 1002a Chestnut St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ROBERT Middle J. ~~Peter~~ Last CLARKE

4. DATE OF DEATH Month JAN. Day 12, Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 31st 1886
9. AGE (In years last birthday) 72 — 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) Iron moulder
10b. KIND OF BUSINESS OR INDUSTRY Moulding
11. BIRTHPLACE (City and state or country) St. Louis, Mo
12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME Joseph Peter Clarke
13b. MOTHER'S MAIDEN NAME Elizabeth Haide
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 494-03-8250
17. INFORMANT Mrs. Bertha Carlton — Address 1002a Chestnut St.

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) Peritonitis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Perforated Pre Pyloric Ulcer
DUE TO (c) 540.1
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ 1

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 1/10/59 to 1/12/59 and last saw her/him alive on 1/12/59
Death occurred at 7:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Donald W. Jackhaw M.D.
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 1/12/59

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE Jany. 14, 1959
23c. NAME OF CEMETERY OR CREMATORY St. Matthew Cem.
23d. LOCATION (City, town, or county) Batis at Gravois (State) Mo

24. FUNERAL DIRECTOR Bull-Campbell Mortuary — ADDRESS 5165 Delmar
25. DATE RECD. BY LOCAL REG. JAN 13 '59
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M.I.B.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. 4108

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.