

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006986  
STATE FILE NUMBER

1361

FILED FEB 24 1959 Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Grand Tower</b>
c. FULL NAME OF (If NOT in hospital, give location) St. Louis <b>Little Rock Hosp, Inc.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>Route # 1</b>
3. NAME OF DECEASED (Type or print) <b>William Albert Clutts</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Section Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	9. AGE (In years last birthday) <b>59</b>
11. BIRTHPLACE (City and state or country) <b>Anna, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lee Clutts</b>		14. MOTHER'S MAIDEN NAME <b>Nora Beaty</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>356-67-1086</b>	17. INFORMANT Address <b>Ethel Clutts, Howardton, Ill.</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>MASSIVE HEMORRHAGE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS -</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>RUPTURE OF ANEURYSM OF ABDOMINAL AORTA -</b> DUE TO (c) <b>ARTERIO SCLEROSIS -</b>			<b>3 DAYS -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>451X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 a. m. p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>February 4, 1959</b> , to <b>February 7, 1959</b> and last saw <sup>him</sup> <del>her</del> alive on <b>February 6, 1959</b> Death occurred at <b>5:15 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Henry [Signature] M.D.</b>		22b. ADDRESS <b>1755 So. Grand Ave.</b>	22c. DATE SIGNED <b>7 Feb 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walker Hill Cemet.</b>	23d. LOCATION (City, town, or county) (State) <b>Murphysboro, Ill.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Crawshaw Funeral Home - Murphysboro, Ill.</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 9 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Official Certifier to a death due to natural causes. Cause of death must be stated. Cause of death must be stated. Cause of death must be stated.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Clarence M. Bill*

Licensed Embalmer No. 4..

P. O. Address *St. Louis,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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. - -