

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007859
STATE FILE NUMBER

FEB 24 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 464

300
-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Clayton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kinloch, Missouri</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>County Hospital</u> Length of stay in lb <u>12 days</u>		d. STREET ADDRESS (If outside, give location) <u>Kinloch, Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Howard</u> Last <u>Howard</u>			4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>59</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1891</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u>6</u> Min. <u>9</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Pickers Co. Ala</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Wright Bonner</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Harris</u>	14. NAME OF HUSBAND OR WIFE <u>Herane Howard</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Clemmie Trust 1223 Scuddle</u>
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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>Exsanguination Into Peritoneal Cavity.</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Post-operative condition for retroperitoneal lipo sarcoma.</u>		
DUE TO (c) <u>158X</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parenchymatous Degeneration of kidneys - Acute Passive Congestion of Liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.)	
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20c. TIME OF INJURY Hour <u>10:10 p.m.</u> Month, Day, Year <u>2-13-59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. CITY, TOWN, OR LOCATION <u>Berkly, Missouri</u> COUNTY <u>Berkly</u> STATE <u>Missouri</u>
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21. I attended the deceased from <u>2-2-59</u> to <u>2-13-59</u> and last saw her ^{him} alive on <u>2-13-59</u> Death occurred at <u>10:10 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>J. Garrison, Jr. M.D.</u>	22b. ADDRESS <u>601 So. Brentwood</u>	22c. DATE SIGNED <u>2-16-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2/19/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	23d. LOCATION (City, town, or county) (State) <u>Berkly, Missouri</u>
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24. FUNERAL DIRECTOR <u>E. B. Koone</u> ADDRESS <u>1221 N Grand</u>	25. DATE RECD. BY LOCAL REG. <u>2-17-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Melvin Black*
Licensed Embalmer No. *3962*
P. O. Address *1221 N. 2nd*

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.