

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010799
STATE FILE NUMBER
2-2074
Registrar's

ED MAR 17 1959 Registration District No. _____ Primary Registration District No. _____

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</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>5332 Maffitt</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>5332 Maffitt</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle Last <u>Clark</u> | | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar 15, 1878</u> | | 9. AGE (In years last birthday) <u>80</u> IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nil</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Tenn</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE | |
| 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. | 17. INFORMANT <u>Rebecca J Thompson</u> Address <u>5332 Maffitt</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>Cerebral Embolus</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2. 20. 59.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> <u>1959</u> | | | | | |
| DUE TO (c) <u>Generalized Arteriosclerosis</u> | | | | | <u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.0</u> | | | | | 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>2-15-59</u> to <u>2-21-59</u> and last saw ^{him} alive on <u>2-21-59</u> Death occurred at <u>12 MIDNIGHT</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>J. C. Sheard, M.D.</u> | | | 22b. ADDRESS <u>2702 Franklin</u> | | 22c. DATE SIGNED <u>2-26-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>Feb 28 59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County MO</u> |
| 24. FUNERAL DIRECTOR <u>F. A. Green</u> | | ADDRESS <u>4214 Delmar</u> | 25. DATE RECD. BY LOCAL REG. <u>FEB 27 '59</u> | | 26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u> |

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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 embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *J. A. Green*

Licensed Embalmer No. *2963*
P. O. Address *4214 Delmar*

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.