

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011166
STATE FILE NUMBER
2 1664
Registrar's No.

18 MAR 18 1959 Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Affton 4820	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Paroute City Hospital		d. STREET ADDRESS (If outside, give location) 9221 Arrow Dr.	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
Clayton	C.	McKenzie	February	13,	1959

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1924	9. AGE (In years last birthday) 34	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
-----------------------	----------------------------------	---	--	--	---	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Calloway Co., Ky.	12. CITIZEN OF WHAT COUNTRY? U.S.
---	-----------------------------------	--	---

13a. FATHER'S NAME Buel McKenzie	13b. MOTHER'S MAIDEN NAME Necie McDougal	14. NAME OF HUSBAND OR WIFE Velda
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Horace McKenzie, Murray, Ky.	Address
--	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage following ruptured liver.		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) E 978X	
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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II, if from 18.) Jumped from McArthur Bridge Feb 13th, 1959 about 7:14 a.m.
--	---

20c. TIME OF INJURY 7:14 a.m. 2-13-59	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.) Bridge	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY	STATE
---	---	---	--	--------	-------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Patrick J. Taylor Carver	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 2-16-59
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-16-59	23c. NAME OF CEMETERY OR CREMATORY Murray Memorial Gardens	23d. LOCATION (City, town, or county) (State) Murray, Ky.
---	-----------------------------	--	---

24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. FEB 16 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
---	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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 *Lawrence O. Gehring*

Licensed Embalmer No. *4979*
P. O. Address *St. Louis*

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.