

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015297

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2772**

FILED MAY 1 1959

Health, Welfare, Public Service

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony</b>		Length of stay in lb <b>5 Weeks</b>	d. STREET ADDRESS (If outside, give location) <b>3250 So Grand Blvd</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>C</b> Last <b>LARKIN</b>			4. DATE OF DEATH Month <b>3</b> Day <b>17</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-1-1879</b>
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>
13a. FATHER'S NAME <b>Peter Larkin</b>		13b. MOTHER'S MAIDEN NAME <b>Ellen Burk</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Rose A O'Reilly</b> Address <b>3250 So Grand Blvd</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>Arterio-sclerotic heart disease with myocardial damage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cerebral Sclerosis with partial left hemiplegia</b> DUE TO (c) <b>Senile Psychosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>6 mos.</b> <b>3 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>			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 _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT WORK <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 <b>January 1950</b> to <b>Mar. 17-59</b> and last saw her <sup>her</sup> alive on <b>Mar. 16-59</b> . Death occurred at <b>2/15 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>George A. O'Sullivan, M.D.</b> (Degree or title)		22b. ADDRESS <b>7629 Zany Ave.</b>	22c. DATE SIGNED <b>3-18-59</b>
23a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>		23b. DATE <b>3-20-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem/</b>
23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>		23e. (State)	
24. FUNERAL DIRECTOR <b>WINGBERMUEHLE</b> ADDRESS <b>3819 So Grand Blvd</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 18 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

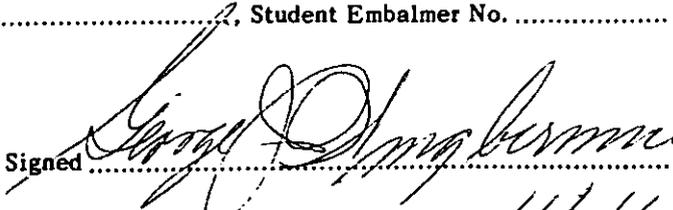
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

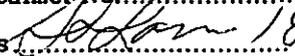
STATEMENT BY LICENSED EMBALMER

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. 4611 .....

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.