

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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|--|--|---|---|---|--|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Length of stay in 1b | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1 | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1123 Dolman | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Clarence H. Kidd | | | | 4. DATE OF DEATH September 20 1959 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4/16/84 | | |
| | | | | 9. AGE (last birthday) 75 | | IF UNDER 1 YEAR Months Days | | |
| | | | | | | IF UNDER 24 HR Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stretcher Bearer | | | 10b. KIND OF BUSINESS OR INDUSTRY City Hospital | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Thomas Kidd | | | 13b. MOTHER'S MAIDEN NAME Hattie Unknown | | | 14. NAME OF HUSBAND OR WIFE Mary H. Buckley | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 499 01 1106 | | 17. INFORMANT Leora Hampton 8802 Bangert Pl 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) Renal Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Renal Abscess DUE TO (c) Acute Pyelonephritis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 1 week 1 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 600.0 | | | | | | PART III. If deceased was female was there a pregnancy in last 90 d.ys. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) 600.0 | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year 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 8-1-59 to 9-20-59 and last saw her/him alive on 9-20-59 Death occurred at 2:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE John W. Strzech M.D. | | | | 22b. ADDRESS 1515 Lafayette Ave. | | | 22c. DATE SIGNED 9-20-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 9/23/59 | 23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon | | 23d. LOCATION (City, town, or county) St. Louis Cty Mo | | (State) | |
| 24. FUNERAL DIRECTOR E.J. Schnur 3125 Lafayette | | | 25. DATE RECD. BY LOCAL REG. SEP 23 1959 | | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Thomas R. Jewick

Licensed Embalmer No. 3793
P. O. Address 3125 Lafayette

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.