

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038268

FILED VS NOV 2 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2744

1. PLACE OF DEATH a. COUNTY <u>St. Louis</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>Clayton</u>			Length of stay in 1b <u>DOA</u>		c. CITY OR TOWN <u>Glendale</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>832 Queen Anne Place</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN LESTER CLARK</u>				4. DATE OF DEATH Month Day Year <u>Oct. 14, 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-98</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Script Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KSD - TV</u>		11. BIRTHPLACE (City and state or country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William T. Clark</u>			13b. MOTHER'S MAIDEN NAME <u>Annie Holmes</u>			14. NAME OF HUSBAND OR WIFE <u>Pauline W. Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W. W. I.</u>			16. SOCIAL SECURITY NO. <u>165-09-4450</u>		17. INFORMANT Address <u>832 Queen</u> <u>Mrs. Pauline Clark, Anne Pl.</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>Acute Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Partial Coronary occlusion</u>						<u>2 wks</u>	
DUE TO (c) <u>Chronic Cardio nephritis</u>						<u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitis 12 yrs.</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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. Month, Day, Year							
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 <u>Oct 3, 1959</u> to <u>Oct 14, 1959</u> and last saw her/him alive on <u>Oct 10, 1959</u> . Death occurred at <u>8:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>L. G. Milliken MD</u>				22b. ADDRESS <u>2608 S. Kingshighway</u>		22c. DATE SIGNED <u>10/16/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>10-17-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>		
24. FUNERAL DIRECTOR <u>Parker-Aldrich, Webster Groves</u>				25. DATE RECD. BY LOCAL REG. <u>10-16-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

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

*Leslie Welch*

Licensed Embalmer No. 4395

P. O. Address Walter Gro

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.