

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH
FILED VS JAN - 4 1960

211726 '59 0 4 5 3 1 9
 STATE FILE NUMBER

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

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Hosp		d. STREET ADDRESS (If outside, give location) 2500 N. Sarah St.	
3. NAME OF DECEASED (Type or print) First Pleas Middle Clinton Last		4. DATE OF DEATH Month 12 Day 17 Year 59	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11.5.1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Meridan Miss	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Pleas J. r Clinton		13b. MOTHER'S MAIDEN NAME Marth Blanks	14. NAME OF HUSBAND OR WIFE Ola Clinton
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. 489-05-2887	17. INFORMANT Address Ola Clinton 2500 N. Sarah St.
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Arterio sclerosis DUE TO (c) 331 X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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			INTERVAL BETWEEN ONSET AND DEATH
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 _____ to _____ and last saw him/her alive on _____ Death occurred at _____ 12 NOON on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Patrick C. Taylor Coroner		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 12.18.59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/30/59	23c. NAME OF CEMETERY OR CREMATORY Greenwood	23d. LOCATION (City, town, or county) (State) St. Louis County Mo
24. FUNERAL DIRECTOR Boyd Bros 3706 Finney Ave		25. DATE RECD. BY LOCAL REG. DEC 18 1959	26. REGISTRAR'S SIGNATURE Neal Smith M.D. <i>mgB</i>

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 Henry C. Williams

Licensed Embalmer No. 4781

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.