

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

2 3353

60-012447

STATE FILE NUMBER

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 <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u> | | Length of stay in 1b | c. CITY OR TOWN <u>ST. Louis</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>Homer Phillips Hosp</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>4743 Labadie</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>T.</u> Last <u>Clark</u> | | | 4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1960</u> | | | |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</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>11-30-1877</u> | 9. AGE (last birthday) <u>82</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Osteopath</u> | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (City and state or country) <u>Virginia</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME <u>Chas. Clark</u> | 13b. MOTHER'S MAIDEN NAME <u>Julia</u> | 14. NAME OF HUSBAND OR WIFE <u>Margaret</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Span Amer WWI</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Margaret Clark</u> | Address <u>4743 Labadie</u> |
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| 48. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | Respiratory Failure <u>Medullary failure</u> | <u>5 min.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | <u>Respiratory Failure</u> | <u>5 min.</u> |
| DUE TO (b) | <u>cerebral encephalomalacia</u> | |
| DUE TO (c) | <u>Cerebral Encephalomalacia 332+</u> | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>arteriosclerosis, cerebral</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 |
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| 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.) |
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| 20c. TIME OF INJURY Hour _____ e.m. _____ p.m. | Month, Day, Year |
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|--|--|------------------------------|--------|-------|
| 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 1956 to 3-22-60 and last saw him alive on 3-18-60
Death occurred at 1:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Martin Glazer</u> (Degree or title) <u>Martin Glazer M.D.</u> | 22b. ADDRESS <u>5507 Pershing</u> <u>5507 Pershing Ave.</u> | 22c. DATE SIGNED <u>3/13/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>3-25-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>National</u> | 23d. LOCATION (City, town, or county) <u>Jefferson BKs Mo</u> |
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| 24. FUNERAL DIRECTOR <u>A. Krow</u> | ADDRESS <u>2707 N. Grand Bl.</u> | 25. DATE RECD. BY LOCAL REG. <u>MAR 24 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u> |
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Hector J. Law Jr.

Licensed Embalmer No. 4800

P. O. Address Richwood 22

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.