

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033254

STATE FILE NUMBER

FILED **WS SEP 12 1960**

Registration District No. **317**

Primary Registration District No. **547**

Registrar's No. **2472**

INDEXED

1. PLACE OF DEATH a. COUNTY St. Louis		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 Richmond Heights		Length of stay in 1b	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4210 Botanical Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Grace Middle C. Last Clithero	4. DATE OF DEATH Month August Day 18 Year 1960
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5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-19-1888	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Canyon City, Colo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME T.J. Claggett	13b. MOTHER'S MAIDEN NAME Lillian Witherspoon	14. NAME OF HUSBAND OR WIFE Dr. W.H. Clithero
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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) no none	16. SOCIAL SECURITY NO. none	17. INFORMANT Dr. W.H. Clithero 4210 Botanical Address St. Louis Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Heart DUE TO (b) Anxiety and Depression DUE TO (c) Chr. Cholelithiasis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH 8/17/60 8/18/60
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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 checked="" 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 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
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21. I attended the deceased from **May 23, 1960** to **Aug. 18, 1960** and last saw her ^{her} alive on **Aug. 18, 1960**
Death occurred at **6:55 PM Aug. 18, 1960** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>James P. Wade M.D.</i> (Degree or title)	22b. ADDRESS (3) Mo. 634 North Grand Ave. St. Louis	22c. DATE SIGNED 8-19-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Aug. 23, 1960	23c. NAME OF CEMETERY OR CREMATORY OAK GROVE	23d. LOCATION (City, town, or county) (State) ST LOUIS CO. MO
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24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar Bly'd. ADDRESS	25. DATE RECD. BY LOCAL REG. 8-19-60	26. REGISTRAR'S SIGNATURE <i>John E. Murphy M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 02 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Clarence H. M...

Licensed Embalmer No. 40

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign 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.