

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Saint Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 2250 Cass, Apt. 703	

3. NAME OF DECEASED (Type or print) First EFFIE Middle NMN Last CLAYTON			4. DATE OF DEATH Month SEPTEMBER Day 28 Year 1960		
5. SEX Female	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 4/23/91	9. AGE (last birthday) 69	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) Housework		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (City and state or country) Benton CO., Miss.	
13a. FATHER'S NAME Unknown Hicks			13b. MOTHER'S MAIDEN NAME Minerva (Unknown)		14. NAME OF HUSBAND OR WIFE Joe Clayton

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. None	17. INFORMANT Pearlie Mason, 2250 Cass, Apt. 703
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) MESENTERIC ARTERY THROMBOSIS		24 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ATHEROSCLEROSIS	UNDETERMINED
	DUE TO (c) 450.0	

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 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.)
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20c. TIME OF INJURY Hour 3:30 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 Holly Springs, Miss.
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21. I attended the deceased from SEPT. 10, 1960 to SEPT. 28, 1960 and last saw her/him alive on SEPT. 28, 1960 Death occurred at 3:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>C. E. Vermillion, M.D.</i> (Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 9/29/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/1/60	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Holly Springs, Miss.
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24. FUNERAL DIRECTOR Charles J. Gates, 4107 Finney	25. DATE RECD. BY LOCAL REG. SEP 29 1960	26. REGISTRAR'S SIGNATURE <i>Lead Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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 _____
Licensed Embalmer No. 1825

P. O. Address 4107 Finney

STATEMENT BY LICENSED EMBALMER

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.