RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11016 STATE FILE NUMBER 60-044322

DED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Lukes Hospital
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 4605 Lindell
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Nancy Middle: Last: Van Cleave

4. DATE OF DEATH Month Day Year: November 14, 1960

5. SEX: female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 1/21/93
9. AGE (last birthday): 67
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): At home
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (City and state or country): Butler, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: William Blair
13b. MOTHER'S MAIDEN NAME: Mary Frances Crowder
14. NAME OF HUSBAND OR WIFE: Lee W. Van Cleave

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: C.W.Allison Address: 439 N. Hanley, ClaytonMo

MEDICAL CERTIFICATION

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)	Cardiac tamponade	several min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Rupture of dissecting aortic aneurysm	6 days
DUE TO (c)	451X	

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 February 1940, to Nov.14, 1960 and last saw her/him alive on November 14, 1960
Death occurred at 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Benjamin H. Clarke (Degree or title) M.D.
22b. ADDRESS: 3720 Washington Blvd, St.Louis 8
22c. DATE SIGNED: 11/15/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Nov. 17, 1960
23c. NAME OF CEMETERY OR CREMATORY: Bellefontaine Cem.
23d. LOCATION (City, town, or county) (State): St. Louis Missouri.

24. FUNERAL DIRECTOR: C.R. Lupton and Sons ADDRESS: 7233 Delmar Blv'd.
25. DATE RECD. BY LOCAL REG.: NOV 15 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

BY AFFIDAVIT OF DOCUMENT

NOV 30 1960

MAR 10 1961

Van Cleave
City Vise

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 Clarence H. Mu

Licensed Embalmer No. 4011

P. O. Address St. Louis

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