

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-039468**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2971

AMENDED

FILED NOV 8 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	<b>St. Louis County</b>	a. STATE	<b>Mo.</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	<b>Webster Groves, Mo.</b>	b. COUNTY	<b>ST LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	<b>404 Oakwood Ave.</b>	c. CITY OR TOWN	<b>Webster Groves</b>
Length of stay in 1b	<b>YES</b>	d. STREET ADDRESS (If outside, give location)	<b>404 Oakwood Ave.</b>
Inside Limits	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	<b>Helen</b>	<b>Hackney</b>	<b>Clausen</b>	<b>Oct.</b>	<b>23</b>	<b>1961</b>	

5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
<b>F.</b>	<b>W.</b>		<b>7/22/89</b>	<b>72</b>	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY		
<b>Housewife</b>		<b>none</b>	<b>Atchison, Kansas</b>	<b>U. S. A.</b>		

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
<b>H. H. Hackney</b>	<b>Francis Blair</b>	<b>Erwin Werner Clausen</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		<b>W. M. Johnson,</b>	<b>404 Oakwood Ave.</b>

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) <b>Cerebral arteriosclerosis - Chronic brain Syndrome</b>	<b>Over 5 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b)	
DUE TO (c)	

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.
<b>Arteriosclerotic heart disease</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
		<b>---</b>

20c. TIME OF INJURY	Hour	Month, Day, Year
	<b>a.m.</b>	<b>---</b>

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
	<b>---</b>	<b>---</b>		

21. I attended the deceased from 1939 to 10-23-61 and last saw ~~him~~ **her** alive on 10-22-61  
 Death occurred at 12:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED
<i>[Signature]</i>		<b>19 E. Lockwood Ave., Webster Groves 19, Missouri.</b>	<b>10.23.61</b>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
<b>Removal</b>	<b>10/24/61</b>	<b>Mt. Vernon</b>	<b>Atchison, Kansas</b>	

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<b>Parker-Aldrich,</b>	<b>Webster Groves, Mo.</b>	<b>10-23-61</b>	<i>[Signature]</i>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Leslie Balch

Licensed Embalmer No. 4395

P.O. Address Walter Green

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.