

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-047109

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3697

STATE FILE NUMBER

1. FILED BY DEATH JAN 9 1962		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Louis</u>		a. STATE <u>New York</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy, Missouri</u>		c. CITY OR TOWN <u>Brooklyn</u>	
Length of stay in 1b <u>20 days</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>ST. VINCENT'S HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>Ridge Blvd. and 89th Street</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SISTER CLAUDE MARGUERITE CLARK</u>			4. DATE OF DEATH Month Day Year <u>Dec. 26, 1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/91</u>
9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>8</u>	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	11. BIRTHPLACE (City and state or country) <u>Brooklyn, New York</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas H. Clark</u>	
13b. MOTHER'S MAIDEN NAME <u>Anna Campbell</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Nil.</u>	
17. INFORMANT <u>Mother Mary Agnes Vistation Convent Records of St. Vincent's Hospital</u>		Address	
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) <u>Hemiplegia due to Cerebral Thrombosis</u>			<u>8 days</u>
DUE TO (b) <u>Cerebral Arteriosclerosis</u>			<u>Years</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u>			<u>II</u>
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
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.)			
20c. TIME OF INJURY Hour 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 COUNTY STATE
21. I attended the deceased from <u>Dec. 6, 1961</u> to <u>Dec. 26, 1961</u> and last saw her <u>live</u> on <u>Dec. 26, 1961</u>			
Death occurred at <u>8:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph A. Cantone M.D.</u>		22b. ADDRESS <u>2425 N. B. Hwy, St Louis 8</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-26-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kings County, New York</u>
24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>12-26-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Haines
Licensed Embalmer No. 4408

P. O. Address St. Louis

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.