

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4134-62-016672
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

VS 300
Rev. 4/59

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2 *212*
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

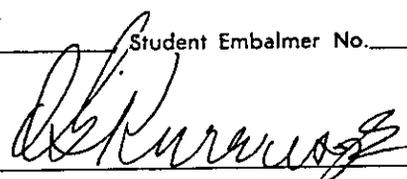
USE BLACK INK OR TYPEWRITER RIBBON

1. FILED MAY 1 1962		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY ST. LOUIS, MISSOURI		a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
Length of stay in 1b 3 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 600 N. Kingshighway	
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)			4. DATE OF DEATH
First MARIE Middle RUTH Last CLARK			Month APRIL Day 19 Year 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1900
9. AGE (last birthday) 61		IF UNDER 1 YEAR IF UNDER 24 HR	
		Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing Profession	11. BIRTHPLACE (City and state or country) St. Henry, Ohio
		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME J. J. Bany		13b. MOTHER'S MAIDEN NAME Rosa Marie Mackey	14. NAME OF HUSBAND OR WIFE James Preston Clark
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 Address 3794 Berkley Rd Mrs. Florence Benton, Cleveland, Ohio
18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) HEPATIC COMA			2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) LAENNEC'S CIRRHOSIS			YEARS
DUE TO (c) _____			581.1
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 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.)	
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 OCT. 16, 1940 to APRIL 19, 1962 and last saw her alive on APRIL 19, 1962			
Death occurred at 12:10 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. P. Vermillion, M.D.</i> (Degree or title) M.-D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 4/20/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-23-62	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
24. FUNERAL DIRECTOR C. G. Kurrus, Jr., E. St. Louis, Ill ADDRESS _____		25. DATE RECD. BY LOCAL REG. APR 20 1962	26. REGISTRAR'S SIGNATURE <i>Head Smith, M.D.</i>

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  _____

Licensed Embalmer No. 3162

P. O. Address E. St. Louis, Illinois

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.