

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-045316

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11750**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 12 1963

VS 300 Rev. 4/59	DATE AMENDED	1			
2		81-908	3	4	1
5		2	6	7	9
8		1	9	10	11
12		52-0	11	12	13
13		52	12	13	14
14		15	16	17	18
19		20	21	22	23
24		25	26	27	28
29		30	31	32	33
34		35	36	37	38
39		40	41	42	43

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b 1 hour		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY		c. CITY OR TOWN Mount-Vernon		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 706 North 12th				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Blanche Clark						4. DATE OF DEATH Month Day Year Nov. 27 1963					
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 8/14/02		9. AGE (last birthday) 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Unknown 9		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Unknown				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE Harold Clark-deceased			
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.		17. INFORMANT Mrs. Robert Whitaker - daughter 3113 Apple, Mt. Vernon, Illinois			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cerebral hemorrhage								INTERVAL BETWEEN ONSET AND DEATH 24 hours			
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. <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.) 331X							
20c. TIME OF INJURY Hour a.m. p.m.		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 _____ on 11/27/63 and last saw her alive on 11/27/63 Death occurred at 6:15 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <i>Ann Levy M.D.</i>						22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 11/28/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-2-63		23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Memorial Park		23d. LOCATION (City, town, or county) Paramus, N. J.		(State)			
24. FUNERAL DIRECTOR Myers Funeral Home Mt. Vernon, Illinois						25. DATE RECD. BY LOCAL REG. NOV 28 1963		26. REGISTRAR'S SIGNATURE <i>Paul 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 James J. Cossin

Licensed Embalmer No. 5168

P. O. Address Millstadt, 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.