

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.---Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

8770
Do not use this space.

1. PLACE OF DEATH

(a) County..... | Registration District No.....
 (b) Township..... | Primary Registration District No.....
 (c) City..... **St. Louis** | (d) Street No..... **Mo. Baptist Hosp.** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 452 **Martin N. Clinkingbeard**

(a) Residence, No. **3107 Sutton** St. **NR** **Maplewood, Mo.**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Millie Clinkingbeard

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb. 28, 1883**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 0 16

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Store Keeper**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Leasburg Mo.**

FATHER 13. NAME **Joseph Clinkingbeard**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

MOTHER 15. MAIDEN NAME **Nancy J. Burnett**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

17. INFORMANT (ADDRESS) **Millie Clinkingbeard 3107 Sutton**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Valhalla** DATE **March 17, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Jay B. Smith 7456 Manchester**

20. FILED **MAR 17 1939** *J. B. Baker* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **March 14, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **March 10, 1939**, to **March 14, 1939**
 I last saw him alive on **March 14, 1939**. Death is said to have occurred on the date stated above, at **8:15 P.M.**
 The principal cause of death and related causes of importance were as follows:

Hypostatic Pneumonia Unspecified
Chronic Alcoholism
 Other contributory causes of importance:
 Date of onset **March 14, 1939**

Name of operation **none** Date of _____
 What test confirmed diagnosis? **Physical findings** Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? **No**
 If so, specify _____
 (Signed) **Donald F. Townsend** M. D.
 (Address) **3101 Sutton Ave Maplewood Mo**

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

H. P. Burgess

Licensed Embalmer No.....

4029

P. O. Address.....

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 this body is not embalmed, above space should be left blank.