

AUG 11 1939

ISOLATION HOSPITAL

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

24156
Do not use this space.

6429

1. PLACE OF DEATH

(a) County..... 1 Registration District No..... 791
 (b) Township..... 1 Primary Registration District No..... 1003
 (c) City or St. Louis Mo (d) Street No. 5600 ARSENAL 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 20 yrs. 7 mos. 1 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME DAVID CLARKE 462

(a) Residence, No. 3928 N. WHARF St. 26 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DECEMBER 19-1911

| | | | | |
|--------|-----------|----------|----------|--|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day,hrs. ormin. |
| | <u>27</u> | <u>7</u> | <u>1</u> | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. LIFEGUARD

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) MISSOURI 0

FATHER

13. NAME JOHN M. CLARKE 0

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS MO 1

MOTHER

15. MAIDEN NAME MARGARET ROBINSON

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KEOKUK, IOWA

17. INFORMANT (ADDRESS) A. LANE
5600 ARSENAL ST.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Concordia Cem. DATE July 22, nd. 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ziegenhain Bros.
2623 Cherokee Street.

20. FILED JUL 21 1939 JTB Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 20 1939

22. I HEREBY CERTIFY, That I attended deceased from July-13 1939 to July 20 1939.
 I last saw him alive on July 20 1939. Death is said to have occurred on the date stated above, at 3:25 A. m.
 The principal cause of death and related causes of importance were as follows:
Typhoid Fever Date of onset

Other contributory causes of importance:
none

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? Yes

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? None (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?
 If so, specify.....
 (Signed) Geo. S. Boyalman M. D.
 (Address).....

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.

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 Juddie A. Ziegenhein
Licensed Embalmer No. 2270.

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.