

Registration District No. **7003** Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Saint Louis
(b) City or town _____
(c) Name of hospital or institution: BARNES HOSPITAL
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

3. (a) PRINT FULL NAME VERA SOPHIA CLAYBURN
3. (b) If veteran, name war none 3. (c) Social Security No. _____
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Edward Clayburn 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased April 5, 1894

8. AGE: Years 45 Months 8 Days - If less than one day _____ hr. _____ min.

9. Birthplace Brooklyn, N. Y.
10. Usual occupation Housewife

11. Industry or business _____
12. Name Rapport
13. Birthplace Unknown N. Y.
14. Maiden name Unknown N. Y.
15. Birthplace _____

16. (a) Informant's own signature E. Clayburn
(b) Address 2013 S. Compton
17. (a) Cremation (b) Date thereof Dec. 8, 1939
(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Craig Mortuary
(b) Address 4468 Washington Blvd.
19. (a) DEC 6 1939 (Date received by registrar)
(b) J. P. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis
(d) Street No. 2013 S. Compton
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 5th year 1939 hour 10 minute 06 P.M.

21. I hereby certify that I attended the deceased from December 4, 1939, to December 5, 1939; that I last saw her alive on December 5, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral embolism
Cardiac decompensation
Auricular fibrillation
Pneumonia
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings of operations Multiple infarcts liver, spleen, brain
Of autopsy Cause unknown non-tubercular

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
28. Signature M. Anderson (M. D. or other)
Address BARNES HOSPITAL Date signed 12-6-39

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

Stacy M. Craig

Licensed Embalmer No. 3281

P. O. Address..... 4468 Washington Blvd.....

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.