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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3547

Registrar's No. 130

Registration District No. 4

Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.  
(b) City or town Manchester  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Manchester Nursing Home 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether

In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Clara Scown

3. (b) If veteran, name war..... 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife William Scown 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased October 15, 1868  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 3 1 hr. min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

12. Name Levi Crum

13. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Sadie Scown

(b) Address 4919 Natural Bridge Ave.,

17. (a) Burial (b) Date thereof 1/19/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director Albert H. Hoppe, Inc

(b) Address 4700 Washington Blvd.,

19. (a) JAN 19 1943 (b) C. G. Mc Lawren  
(Date received) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town Manchester  
(If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 16 day.....  
year 43 hour 7:45 minute A M.

21. I hereby certify that I attended the deceased from Nov 29  
1942 to Jan 16 1943

that I last saw her alive on Jan 13 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Gripesclerosis  
Senile psychosis

Due to.....  
Due to.....

Other conditions 97  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

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?..... (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)  
(c) Means of injury.....

23. Signature H. L. Goley (M. D. or other)  
Address 4919 Natural Bridge Date signed Jan 16-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP. 28 1943

**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

*Albert W. Hopper*

Licensed Embalmer No. *1861*

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, fact should be so stated above.

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