S. No. 2
M—8-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

3323

State File No.

FILED FEB 13 1945

Registration District No. 3[illegible]

Primary Registration District No. 6076

Registrar's No. 392

1. PLACE OF DEATH:

(a) County Koch St Louis Co.

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 36 days (Specify whether

In this community 10 yrs ? D
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0 0 0 17

(c) City or town St Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 1025 Compton
(If rural, give location)

(e) Citizen of foreign country? No 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME BERNICE CLARK

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEM 3

5. Color or race Col

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased 6 (Month) 5 (Day) 1922 (Year)

8. AGE:

Years	Months	Days	If less than one day
22	7	29	hr. min.

9. Birthplace ? (City, town, or county) Mississippi (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name JAMES CLARK
13. Birthplace ? (City, town, or county) Miss. (State or foreign country)

MOTHER
14. Maiden name VELMA SHOEMARE
15. Birthplace ? (City, town, or county) Miss. (State or foreign country)

16. (a) Informant Patient

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director J. H. Handle & Son

(b) Address 3133 Bell Ave

19. (a) FEB 9 1945 (Date received local registrar) (b) E. G. McGavran (Registrar's signature) CMA

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 2 day 3 year 1945 hour 12 minute 10 P. M.

21. I hereby certify that I attended the deceased from 12-29-44, 19__, to 2-3, 1945 that I last saw her alive on 2-3, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	1 yr ?
Due to: Pulmonary Tbc	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 13 h

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Bernard Freedman (M. D. or other) M.D.

Address Robt. Koch Hosp. Date signed 2/3/45

(Licensed Embalmer's Statement on Reverse Side)

MAY 10 1945

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 S. H. Watson

Licensed Embalmer No. 269 J

P. O. Address 2769 Choate

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.