

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 10 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 22337
Registrars No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo-Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Morgan
(c) City or town Jacksonville
(If outside city or town limits, write "RURAL")
(d) Street No. 1831 Mound Rd.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph Michael Clancy
3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Child
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 5 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 0 26 hr. min.

9. Birthplace Jacksonville Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER
12. Name William Clancy
13. Birthplace Jacksonville Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Lucy Wilson
15. Birthplace Franklin Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant William J. Clancy
(b) Address Jacksonville, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-31-47
(Month) (Day) (Year)

(c) Place: burial or cremation Jacksonville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) JAN 31 1947 (Date received local registrar)
(b) J. F. Bredack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 31
year 1947 hour 4 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from 1/30/47
_____ 19 _____ to 1/31/47 19 _____
that I last saw him alive on 1/31/47 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Stroke of Brain
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy Same
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?
While at work? _____ (Specify type of work) (e) Means of injury _____
23. Signature D. M. Keenan (M.D. or other) M.D.
Address 4955 Maryland Date signed 1/31/47

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

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.....

Henry M. Brammer

Licensed Embalmer No.....

4200

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.