

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6112**

COMMERCIAL
THE CENSUS
FEB 24 1947

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **353**

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

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:
St. Louis Children's Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Kenneth Paul Clark

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced INFANT

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

7. Birth date of deceased DEC. 7 1946
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>2</u>	<u>2</u>	hr. _____ min. _____

9. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

10. Usual occupation INFANT

11. Industry or business _____

MOTHER { 12. Name EMIL CLARK
 13. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)
 14. Maiden name MILDRED JONES
 15. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

FATHER { 16. (a) Informant Mr. Emil Clark
 (b) Address 1321 S. Compton

17. (a) BURIAL (b) Date thereof FEB 11 - 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. MATTHEWS

18. (a) Signature of funeral director E. J. Schuur
 (b) Address 3125 Lafayette Ave.

19. (a) FEB 10 (b) J. F. Busch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1321 So. Compton
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9
 year 1947 hour 12 minute 05 a.m.

21. I hereby certify that I attended the deceased from 12-7- 1947, to 2-9 1947;
 that I last saw him alive on 2-9 1947;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Hepatitis
 Due to Diarrrhea, Acute
 Due to _____

Other conditions 119
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 place) (a) Means of injury

23. Signature J. F. Busch (M. D. or other) _____
 Address _____ Date signed _____

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 *Joe B. Vollmer*.....

Licensed Embalmer No. *4014*.....

P. O. Address *3126 Lafayette Ave*.....

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.