

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 9 1948
318

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

State File No. 42919
Registrar's No. 11954

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution. _____
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Maggie E. Clows

3. (b) If veteran, name war _____ 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 John Gibson Clows 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased December 8, 1880
(Month) (Day) (Year)

8. AGE: Years 67 Months - Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation AT HOME

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Boggs Funeral Home
(b) Address Centralia, Illinois

17. (a) Removal (b) Date thereof 12-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Illinois

18. (a) Signature of funeral director Herman Rudolph, 2nd
(b) Address 5216 Delmar Blvd.

19. (a) DEC 30 1947 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 999

(c) City or town Irvington
(If outside city or town limits, write "RURAL")

(d) Street No. P.O. Box #6
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 2
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26
year 1947 hour 2 minute 10 P. M.

21. I hereby certify that I attended the deceased from Dec 5
1946 to Dec 26, 1947
that I last saw her alive on Dec 26, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death acute myocardial failure

Due to 1. Senility
2. general arteriosclerosis
3. chronic emphysema

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

Major findings:
Of operations _____
Of autopsy same as above

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) _____
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) MD
Address 4702 S. Maple Date signed 12-27-47

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

MOTHER FATHER

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.....

Licensed Embalmer No..... *3880*

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.