

No. 300
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5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
#77018
FILED APR 7 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

10163
State File No. _____
Registrar's No. 2894

Registration District No. 318
Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
St. Louis City Hospital—Max C. Starkloff
(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

3: (a) PRINT FULL NAME CLARA FLEMING

3. (b) If veteran, name war: No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife: John Fleming

6. (c) Age of husband or wife if alive: 59 years

7. Birth date of deceased: May 5 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

57 10 18 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Unknown Ditzer

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 Evelyn Perkins

(b) Address 107 Lincoln, Union, Mo.

17. (a) Burial (b) Date thereof 3-25-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Campbell, Mo.

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

(b) Address 4700 Washington Blvd.

19. (a) MAR 24 1948 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 5745 Chamberlain
Memorial (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd
year 1948 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from 3/13/48
1948 to March 23rd 1948

that I last saw her alive on March 23rd 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: An anemia Duration 2 days

Due to Bronchitis + Pulmonary Fibrosis 10 yrs.

Due to _____

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

Major findings: _____

Of operations: _____

Of autopsy: 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)

(c) Means of injury _____

23. Signature: Joe H. Hanson 3/23/48
1515 Lafayette (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 Chris R. Caldwell
.....
..... Licensed Embalmer No. 4079
.....
..... 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.