

No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAY 7 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1003
18733
3973
Registrar's No. _____

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 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: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
In this community 15 yrs
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Clara Breckenridge
(b) If veteran, _____ (c) Social Security No. _____
name war _____

4. Sex F 5. Color or race cue 6. (a) Single, widowed, married, divorced married
7. Birth date of deceased may 14 1912
(Month) (Day) (Year)

8. AGE: Years 35 Months 11 Days 11
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Jacith Copening
13. Birthplace Burk N.C.
(City, town, or county) (State or foreign country)
14. Maiden name Mrs. L. Clark
15. Birthplace Morganton N.C.
(City, town, or county) (State or foreign country)

16. (a) Informant Loare Breckenridge
(b) Address 3319 Franklin Ave

17. (a) Removal (b) Date thereof 4-27-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Denmaine Ill

18. (a) Signature of funeral director J. F. Bredeck
(b) Address 3133 Bell

19. (a) APR 27 1948 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3319 Franklin
21 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
year 1948 hour 8 minute P M.

21. I hereby certify that I attended the deceased from March 19, 19 48 to April 25, 19 48
that I last saw her alive on April 25, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Duration Undet.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Yes

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) Details of injury _____

23. Signature James M. Whittier (M.D. or other) _____

Address 2601 N Whittier Date signed 4/26/48

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.....

Tyree Hale....., Registered Apprentice No. *221*
working under my personal supervision.

Signed.....

S J Watson
Licensed Embalmer No. *2698*

P. O. Address *2769 Chautau*

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.