

FILED AUG 13 1948

Registration District No. 317

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

State File No. 24872

Registrar's No. 1099

## 1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town CLAYTON  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis County  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 hrs 10 min  
 (Specify whether  
 In this community life  
 years, months or days)

3. (a) PRINT FULL NAME GEORGE CLEMENS

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

4. Sex M 5. Color or race W  
 6. (a) Single, widowed, married, divorced M  
 6. (b) Name of husband or wife EFFIE THORNTON 6. (c) Age of husband or wife if alive 62 years  
 7. Birth date of deceased NOVEMBER 9 1886  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 9 27 hr. min.

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

10. Usual occupation NONE11. Industry or business —

MOTHER FATHER { 12. Name JOHN CLEMENS  
 13. Birthplace TENNESSEE  
 (City, town, or county) (State or foreign country)  
 14. Maiden name SARAH MATTHEWS  
 15. Birthplace ENGLAND SHARPOAT  
 (City, town, or county) (State or foreign country)

16. (a) Informant HOSPITAL RECORDS  
 (b) Address 601 So BRONTWOOD  
 17. (a) CREMATION (b) Date thereof Aug-9-1948  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation VALHALLA CREMATORY  
 18. (a) Signature of funeral director Parthen and Co  
 (b) Address WEBSTER GROVE ST MO  
 19. (a) 8-7-48 (b) Geil of Hospital  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County St. Louis  
 (c) City or town VINITA PARK  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 8147 MADISON  
 (If rural, give location)  
 (e) Citizen of foreign country? — (Yes or No)  
 If yes, name country —

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5  
 year 1949 hour 9 minute 40 M.

21. I hereby certify that I attended the deceased from Aug 5  
3:30 Pm, 1948, to Aug 5th 9:40pm 1948;  
 that I last saw him alive on Aug 5, 1948;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration

Due to Hypertensive Cardio Vascular Disease - accompanying  
 Due to Generalized Arteriosclerosis  
 Other conditions 93d  
 (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) (e) Means of injury —

23. Signature Kary B. Reed M.D. (M. D. or other)  
 Address St. Louis County Hospital Date signed 8/6/48

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*J. Allen Davis*

Licensed Embalmer No. *4053*

P. O. Address..... *St. Louis*

**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.**