No. 300
—10-47
5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

31624

State File No.

FILED OCT 4 1948

Registration District No. 3487

Primary Registration District No. 6076

Registrar's No.

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 556 days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 2:31

(a) State Missouri (b) County

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

(d) Street No. 4349 St. Louis Avenue
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME CLAY, CARL EARL

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Negro

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

6. (b) Name of husband or wife Aline Harris

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

7. Birth date of deceased June (Month) 23 (Day) 1907 (Year)

8. AGE: Years 41 Months 2 Days 18 If less than one day hr. min.

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

10. Usual occupation Asst. to paper hanger

11. Industry or business

FATHER
12. Name George Clay
13. Birthplace St. Charles (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Leona Glasscock
15. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/15/48 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Herman Smith
(b) Address 4247 W Laredo Pkwy

19. (a) 9-13-48 (Date received local registrar) (b) Cecil J. Shaw (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 10 year 1948 hour 11 minute 57 P. M.

21. I hereby certify that I attended the deceased from 3-4-47, 19__, to 9-10-48, 19__; that I last saw him alive on 9-10-48, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1½yrs. (???)
Due to 13	
Due to	
Other conditions (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature John R. Beem (M. D. or other) M.D.
Address Robert Koch Hospital Date signed 9/11/48

(Licensed Embalmer's Statement on Reverse Side)

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. 4341

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.