

S. No. 300  
OM-10-47  
Rev. 5-17-39  
I 3906

41358  
11274

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
FILED JAN 11 1949

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. **818** Primary Registration District No. **1005**

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Park Lane Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Franklin** **36**  
(c) City or town **Robertsville**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **N.R.** (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Nellie Claspill**  
3. (b) If veteran, name war **No** 3. (c) Social Security No. **Unknown**  
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Scott Claspill** 6. (c) Age of husband or wife if alive **68** years  
7. Birth date of deceased **October 3 1881**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Dec.** day **27**  
year **1948** hour **12:25** minute **M.**  
21. I hereby certify that I attended the deceased from **December 23,**  
19 **48** to **Dec. 27,** 19 **48**  
that I last saw her alive on **December 27,** 19 **48**  
and that death occurred on the date and hour stated above.

8. AGE: Years **67** Months **2** Days **24** If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death **Cerebral Hemorrhage** Duration \_\_\_\_\_  
Due to **Hypertension.**  
Due to \_\_\_\_\_  
Other conditions **83**  
(Include pregnancy within 3 months of death)  
Major findings: Of operations **No operations.** Of autopsy **No autopsy.**  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace **Robertsville Missouri**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Housewife**  
11. Industry or business \_\_\_\_\_  
12. Name **Benjamin Rucker**  
13. Birthplace **W. Virginia**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mattie Patton**  
15. Birthplace **Robertsville Missouri**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **Verlin Claspill**  
(b) Address **4057 Castleman Ave.**  
17. (a) **Burial** (b) Date thereof **12-30-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Robertsville, Mo.**  
18. (a) Signature of funeral director **Albert H. Hoppe**  
(b) Address **4700 Washington Blvd.**  
19. (a) **DEC 28 1948** (b) **J. B. Pasater**  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_  
23. Signature **Lindell Blvd.** (City, D. or other) **12/28/48**  
Address **St. Louis, Mo.** 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

*Robert M. Murray*

..... Licensed Embalmer No. *3749* .....

..... P. O. Address *St. Louis, Mo.* .....

**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.**