

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6045

State File No. 1594

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place) <u>45 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hartford</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Barnes Hospital, U</u>				d. STREET ADDRESS (If rural, give location) <u>114-East Date St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ARTHUR</u>		b. (Middle) <u>CHARLES</u>		c. (Last) <u>CLAREY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 17 49</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>May-12-1896</u>		9. AGE (In years last birthday) <u>52</u> IF UNDER 1 YEAR Months <u>9</u> Days <u>5</u> IF UNDER 24 HRS. Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Salem, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13a. FATHER'S NAME <u>Robert Clarey</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Miller</u>		14. NAME OF HUSBAND OR WIFE <u>Alma Bauer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>346-14-0014</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frank M Sorgea Hartford, Ill.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebritis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Reperformed Cerebral Abscess</u> DUE TO (c) <u>Mastoiditis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>5931</u>				INTERVAL BETWEEN ONSET AND DEATH <u>16 da</u> <u>44 days</u> <u>many yrs</u>	
19a. DATE OF OPERATION <u>2-11-49</u> <u>1-11-49 1-3-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Long abscess (L) Mastoiditis (R) Cerebral Abscess Cerebritis (R perforated)</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-3-</u> , 19 <u>49</u> , to <u>2-17</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>49</u> and that death occurred at <u>7:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>George F. Hawk, M.D.</u>				23b. ADDRESS <u>Barnes Hospital,</u>		23c. DATE SIGNED <u>17 Feb 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 21, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery,</u>		24d. LOCATION (City, town, or county) (State) <u>Alton Illinois</u>	
DATE REC'D BY LOCAL HEALTH DEPT. <u>FEB 19 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Kasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert H. Strooper - Alton, Ill.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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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~~.....

..... Student Embalmer No.

working under my personal supervision.

Signed..... Robert H. Straeper.

Signed.....
Student Embalmer

Licensed Embalmer No. 2474

P. O. Address Alton Ill.

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.