

FILED MAR 11 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
State File No. 6049
1938

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): a. STATE ILLINOIS b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SALEM	
c. LENGTH OF STAY (in this place) 36 days			
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital, (1)		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) ROBERT	b. (Middle) C	c. (Last) CLUSTER	4. DATE OF DEATH (Month) (Day) (Year) FEB. 25, 1949
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5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Aug-29-1885	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during <u>one</u> of working life, even if retired) Croner	10b. KIND OF BUSINESS OR INDUSTRY Croner Bros	11. BIRTHPLACE (State or foreign country) Jefferson Co. Ill.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME James Cluster	13b. MOTHER'S MAIDEN NAME Matilda Bernier	14. NAME OF HUSBAND OR WIFE Winneth
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Loran Cluster - Dolan, Ill	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of liver		
ANCEDECENT CAUSES Morbid conditions, if any, giving rise to the above cause* (b) Primary Carcinoma of sigmoid 6 years			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		H/O	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Metastatic Carcinoma of liver 153X	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY): (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan. 19, 1949, to FEB. 25, 1949, and that death occurred at 4:15 p. m., from the causes and on the date stated above.

23a. SIGNATURE James F. Michel, M.D. (Degree or title)	23b. ADDRESS Barnes Hospital.	23c. DATE SIGNED 2/25/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-26-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Salem Illinois
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DATE REC'D BY LOCAL REG. MAR 1 1949	REGISTRAR'S SIGNATURE J. B. Carpenter	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	ADDRESS
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APR 27 1950

886T

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 _____

J. Allen Davis Jr

Signed _____
Student Embalmer

Licensed Embalmer No. *4063*

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.