

FILED APR 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13673**
3302

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Warren	
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 Wright City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Amy b. (Middle) May c. (Last) Clark			4. DATE OF DEATH (Month) (Day) (Year) 4 11 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 1, 1890	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Piedmont, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME William H. Gowen	13b. MOTHER'S MAIDEN NAME Anna Anderson	14. NAME OF HUSBAND OR WIFE Albert Eli Clark
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Winfred Clark	ADDRESS 4019 E. 67th Terrace Kansas City, Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General arteriosclerosis		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 820 321X			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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"/> 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 **April 8, 1949**, to **April 11, 1949**, that I last saw the deceased alive on **April 11, 1949**, and that death occurred at **11:35 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Anthony P. Day M.D.	(Degree or title)	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 4-12-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-14-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Piedmont, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 12 1949 J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Clement McNeary

Signed.....
Student Embalmer

Licensed Embalmer No. 3732

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.