

FILED OCT 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36099

BIRTH NO. _____ REG. DIST. NO. 367 PRIMARY REG. DIST. NO. 4531 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY Warren		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Warrenton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Katie Jane Memorial Home		d. STREET ADDRESS (If rural, give location) 2137 Sidney	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Eliza c. (Last) Clinard			4. DATE OF DEATH (Month) (Day) (Year) Oct. 5 1949		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Aug. 29		9. AGE (In years last birthday) 77		10. CITIZEN OF WHAT COUNTRY? U.S	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Household		11. BIRTHPLACE (State or foreign country) Stoddard Coujty Mo	

13a. FATHER'S NAME George Hunter		13b. MOTHER'S MAIDEN NAME Pernettie Taylor		14. NAME OF HUSBAND OR WIFE Joeseeph C. Clinard	
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. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs W. Hurcules 2137 Sidney	

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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolism recurrent ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sclerotized arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 45:0
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 July 30, 1949, to Oct. 4, 1949 that I last saw the deceased alive on Oct. 4, 1949 and that death occurred at 2:15 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. Moll Hollister M.D.		23b. ADDRESS Warrenton Mo.		23c. DATE SIGNED Oct. 5	
24a. BURIAL, CREMATION, REMOVAL (Specify) Buried		24b. DATE 10/8/49		24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. C. Moydell 1926 Allen			
DATE REC'D BY LOCAL REG. 10-6-49		REGISTRAR'S SIGNATURE Floyd Lagan		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. C. Moydell 1926 Allen	

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

District File Number _____
District Health Officer No. 9
RECEIVED
OCT 17 1949

OCT 22 1949

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 me

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed Dale A. Johnson

Licensed Embalmer No. 4533

P. O. Address 1926 Allen

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.