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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39626
04556

FILED DEC 6 1949

BIRTH NO. _____ REG. DIST. NO. 5317 PRIMARY REG. DIST. NO. 2002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN UNIVERSITY CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN UNIVERSITY CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7252 NORTH MOOR DR		d. STREET ADDRESS (If rural, give location) 7252 NORTH MOOR DR	

3. NAME OF DECEASED (Type or Print) WALTER ROBERT CLARK			4. DATE OF DEATH (Month) (Day) (Year) NOV. 27-1949		
a. (First)		b. (Middle)	c. (Last)		

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG. 29-1880	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASST SALES MGR.	10b. KIND OF BUSINESS OR INDUSTRY AMERICAN STOVE	11. BIRTHPLACE (State or foreign country) Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME CHAS. T. CLARK	13b. MOTHER'S MAIDEN NAME KATE GILMORE	14. NAME OF HUSBAND OR WIFE CHRISTINE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 489-07-5314	17. INFORMANT'S SIGNATURE OR NAME Christine Clark	ADDRESS 7252 NORTH MOOR
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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) Carcinoma of esophagus		INTERVAL BETWEEN ONSET AND DEATH 18 months 150X
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

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) (Min.)	21e. INJURY OCCURRED WHILE AT 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 **May 9, 1949**, to **Nov. 27, 1949** that I last saw the deceased alive on **Nov. 27, 1949**, and that death occurred **all 40 Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert P. Mullen, M.D.	23b. ADDRESS 250 Central, Clayton	23c. DATE SIGNED 11-28-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE Nov. 30-1949	24c. NAME OF CEMETERY OR CREMATORY CALVAR CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.
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DATE REC'D BY LOCAL REG. 11-30-49	REGISTRAR'S SIGNATURE Robert P. Mullen, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Mr. MULLEN	ADDRESS 516 S DELMAR BL
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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.

Student
Student Embalmer

Signed *A. G. Farris*

Licensed Embalmer No. 3384

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.