

FILED OCT 10 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31376**
Registrar's No. **8256**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St Louis 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1903 Coleman st		d. STREET ADDRESS (If rural, give location) 1903 Coleman st 0	
3. NAME OF DECEASED (Type or Print) a. (First) Bessie		b. (Middle) Clark	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Sept 13 1951	
5. SEX F 3	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 24, 1904
9. AGE (In years last birthday) 47		IF UNDER 1 YEAR Months 2 Days 19	
IF UNDER 1 HR. Hours Mins. 		11. BIRTHPLACE (State or foreign country) Monroe La	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10b. KIND OF BUSINESS OR INDUSTRY		13a. FATHER'S NAME Sanford Jones	
13b. MOTHER'S MAIDEN NAME Ledia Godley		14. NAME OF HUSBAND OR WIFE Aaron Clark	
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 Aaron Clark		ADDRESS 1903 Coleman st	
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) My patient died of heart disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arteriosclerosis DUE TO (b) 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 3 yrs 9-1948	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) St. Louis MO	
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 9 , 1948 to 9-13 , 1951, that I last saw the deceased alive on 9-13 , 1951, and that death occurred at 12:45 P.M. , from the causes and on the date stated above.	
22a. SIGNATURE JAMES EVANS JR. (Degree or title)		23b. ADDRESS	
23c. DATE SIGNED 15 Sept		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE Sept 22-51		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St Louis Co Mo		25. FUNERAL DIRECTOR'S SIGNATURE J W Hughes	
25. FUNERAL DIRECTOR'S ADDRESS 2620 Leaverton		DATE REC'D BY LOCAL REG. SEP 18 1951	
REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE J W Hughes	

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 James A. Carter.....

Licensed Embalmer No. 4681.....

P. O. Address 4923 Suburban.....

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.