

FILED JAN 10 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43341

State File No. ....

318

PRIMARY REG. DIST. NO. 1003 Registrar's No. 11381

BIRTH NO. ....		REG. DIST. NO. ....		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11381			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo.				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 3-WKS.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2019			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Bethesda Hospital				d. STREET ADDRESS (If rural, give location) 6402 Morganford Ave.				0	
3. NAME OF DECEASED (Type or Print) Christian		a. (First)		b. (Middle) F.W.		c. (Last) Clausen		4. DATE OF DEATH (Month) (Day) (Year) Dec. 9, 1952	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.		8. DATE OF BIRTH Aug. 1, 1871		9. AGE (In years last birthday) 81	# UNDER 1 YEAR 4	# UNDER 1 YEAR 8	# UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Druggist			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Carson Clausen			13b. MOTHER'S MAIDEN NAME Mary Andresen			14. NAME OF HUSBAND OR WIFE Mrs. Jessie Clausen			
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. not known			17. INFORMANT'S SIGNATURE OR NAME Mrs. Jessie Clausen, 6402 Morganford			ADDRESS
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) <i>Cerebrovascular disease, advanced</i>						INTERVAL BETWEEN ONSET AND DEATH	
		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 checked="" 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)					
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 5810					
22. I hereby certify that I attended the deceased from <u>11/17</u> , 19 <u>52</u> , to <u>12/9</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>12/7</u> , 19 <u>52</u> , and that death occurred at <u>2:20</u> p.m., from the causes and on the date stated above.									
23a. SIGNATURE <i>Thomas W. Parker MD</i>				(Degree or title)		23b. ADDRESS <i>4668 Maryland</i>		23c. DATE SIGNED <i>12/9/52</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec. 11, 1952		24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REG. DEC 10 1952		REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>			25. FUNERAL DIRECTOR'S SIGNATURE <i>J. Donnell</i>		ADDRESS 3840 Lindell Blvd.		

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

(Licensed Embalmer's Statement on Reverse Side)

**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

*Francis Williamson*

Licensed Embalmer No.

*3565*

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.