

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2662**
Registrar's No. **0497**

72404
FILED FEB 2 1954

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS MO			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, MO		c. LENGTH OF STAY (In this place) 2 1/2 Mos	c. CITY OR TOWN ST. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN'S			e. STREET ADDRESS (If rural, give location) 23 1510 So 8th 2237		
3. NAME OF DECEASED (Type or Print) a. (First) Willard b. (Middle) THOMAS c. (Last) CLAY			4. DATE OF DEATH (Month) (Day) (Year) 1 17 54		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 10-30-53	9. AGE (In years last birthday) 2 1/2	IF UNDER 1 YEAR: Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Rolla, Mo.	
13a. FATHER'S NAME Willard W. Clay		13b. MOTHER'S MAIDEN NAME Anna Walls		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS J. EGAN 500 So King Highway		

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dependency, diarrhea hypoglycemia, S.T. hemorrhage			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? 5710	

22. I hereby certify that I attended the deceased from **10-31, 1953** to **1-17, 1954** that I last saw the deceased alive on **1-17, 1954** and that death occurred at **8:30pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. J. Holtzman, M.D.		23b. ADDRESS Childrens Hospital		23c. DATE SIGNED 1-18-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 1-18-54		24c. NAME OF CEMETERY OR CREMATORY Kinder Cemetery	
		24d. LOCATION (City, town, or county) (State) Cuba, Missouri			

DATE REC'D BY LOCAL REG. JAN 18 1954		REGISTRAR'S SIGNATURE Paul A. Shanklin		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Paul A. Shanklin Cuba, Missouri	
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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 e
by me, or by Student Embalmer No.....
working under my personal supervision..

Not Embalmed

Student.....
Signature of Student Embalmer

Signed *Clyde Eaton*

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.