

STANDARD CERTIFICATE OF DEATH

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590

4400
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, write RURAL and give township) Rock Hill		c. CITY OR TOWN Salem	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 2 mo.		e. STREET ADDRESS (If rural, give location) 0331	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rock Hill Rest Home			

3. NAME OF DECEASED (Type or Print) a. (First) Clara b. (Middle) Lee c. (Last) Addison			4. DATE OF DEATH (Month) (Day) (Year) July 19, 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH May 25, 1881		9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (City and State or Foreign Country) Salem, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.		10b. KIND OF BUSINESS OR INDUSTRY At Home	

13a. FATHER'S NAME Ferguson Dent		13b. MOTHER'S MAIDEN NAME Rosine Cook		14. NAME OF HUSBAND OR WIFE George D. Addison	
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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 ADDRESS Barbara Embeck, 6175 Pershing	
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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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemiplegia			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) Hypertension			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic myocarditis			

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) 334X	
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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?	
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22. I hereby certify that I attended the deceased from **MAY 12, 1954**, to **JULY 19, 1954**, that I last saw the deceased alive on **JULY 19, 1954** and that death occurred at **10:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE A. J. Murkin M.D.		23b. ADDRESS 3507 Potomac		23c. DATE SIGNED 7-20-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-20-54		24c. NAME OF CEMETERY OR CREMATORY Cedar Grove		24d. LOCATION (City, town, or county) (State) Salem, Mo.	
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DATE REC'D BY LOCAL REG. 7/20/54		REGISTRAR'S SIGNATURE Heber R. Romberg		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
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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.....
Signature of Student Embalmer

Signed.....
Elton R. Remick

Licensed Embalmer No. *42*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.