

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

6210

Registrar's No.

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

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) OR TOWN St Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
3. NAME OF DECEASED (Type or Print)		d. STREET ADDRESS (If rural, give location)	
a. (First)		b. (Middle)	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
Clay		July 2 1955	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
			July 2 1955
9. AGE (In years last birthday)		10. MONTHS	11. DAYS
2		2	5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
St Louis Missouri		C	
13a. FATHER'S NAME Charles Edward Clay		13b. MOTHER'S MAIDEN NAME Eula Mae Trice	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Eula Mae Clay		ADDRESS 5119a Highland, City	
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)		Subarachnoid Hemorrhage	
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		Partial Atelectasis	
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"/>		7600	
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?			
22. I hereby certify that I attended the deceased from 7-2- , 19 55 , to 7-2- , 19 55 , that I last saw the deceased alive on 7-2- , 19 55 , and that death occurred at 3:20 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title)		23b. ADDRESS	
Frank B. Long, M.D.		110 S. Central, Clayton 5	
23c. DATE SIGNED			
7-14-55			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	
		7-30-55	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
Anatomical Bldg		St. Louis, Mo.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
JUL 19 1955		Carl Smith MD	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Rawland		4104	

(Licensed Embalmer's Statement on Reverse Side)

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

FILED AUG 2 - 1955

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.