FILED SEP 6 1956

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 28218

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7313

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST.LOUISCITY HOSP.#1 — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN ST.LOUIS,MO 2239 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 23 1719A SO.9th ST — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First LOUISE Middle MADELINE Last CLARK

4. DATE OF DEATH Month AUG. Day 7, Year 1956

5. SEX FEMALE

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH FEB.10,1887

9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (City and state or country) ST.LOUIS,MO

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME FREDERICH ALBIETS

14. MOTHER'S MAIDEN NAME SUSANNA BOLLINGER

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 Address ST.LOUISCITY HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 8-12 hrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) 570.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1/25/56, to 8-7-56 and last saw her/him alive on 8-7-56

Death occurred at 10:25 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jean Gin E. Carr M.D.

22b. ADDRESS 1515 LAFAYETTE AVE.

22c. DATE SIGNED 8/8/56

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 8-9-1956

23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem

23d. LOCATION (City, town, or county) (State) St. Louis Mo

24. FUNERAL DIRECTOR Edw Koch & Son — ADDRESS 3516 N. 14th

25. DATE RECD. BY LOCAL REG. AUG 8 1956

26. REGISTRAR'S SIGNATURE J Carl Smith MD MSB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

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..

Student.....
Signature of Student Embalmer

Signed.....

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.