

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32643

State File No. _____

FILED OCT 8 1956

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>547</u>		Registrar's No. <u>2048</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Richmond Heights</u>		c. LENGTH OF STAY (In this place) <u>2 1/2 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1912 E. Grand Blvd</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ward</u> b. (Middle) _____ c. (Last) <u>Clayton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 30 1956</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Dec 21 1905</u>	
9. AGE (In years last birthday) <u>50</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 18 Hrs. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Johnson City, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Dr. John W. Clayton</u>		13b. MOTHER'S MAIDEN NAME <u>Annabelle Cox</u>		14. NAME OF HUSBAND OR WIFE <u>Alice Clayton (nee Hall)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Alice Clayton, 1912 E. Grand Blvd</u>			
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, atherosclerosis, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic glomerulonephritis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>5921</u> _____			
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 <u>8/13</u> , 19 <u>56</u> , to <u>8/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/29</u> , 19 <u>56</u> , and that death occurred at <u>7:00 A.m.</u> , from the causes and on the date stated above.							
23. SIGNATURE (Degree or title) <u>Thomas Parker M.D.</u>				23b. ADDRESS <u>4660 Maryland St. St. Louis, Mo</u>		23c. DATE SIGNED <u>8/30/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 1 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>8/30/56</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Tomke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Math Hermann & Son, Inc., 2161 E. Fair Ave</u>			

(Licensed Embalmers' Statement on Reverse Side)

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

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
Student Embalmer

Student Embalmer No. _____

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

3737

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.