

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38534

FILED OCT 16 1957

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 544 Registrar's No. 2381

1. PLACE OF DEATH
a. COUNTY ST. LOUIS

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)
a. STATE MO. b. COUNTY FRANKLIN

b. CITY (If outside corporate limits, write RURAL and give township) KIRKWOOD

c. LENGTH OF STAY (in this place) 3 YEARS

c. CITY OR TOWN UNION

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION WHITE OAKS NURSING HOME

e. STREET ADDRESS (If rural, give location) R.R. 0360

3. NAME OF DECEASED
a. (First) CLARA b. (Middle) _____ c. (Last) EKEY

4. DATE OF DEATH. (Month) (Day) (Year) SEPT. 24, 1957

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

8. DATE OF BIRTH NOV. 20, 1874

9. AGE (In years, less birthday) 82 10 4 4

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

10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK

11. BIRTHPLACE (City and State or Foreign Country) NEW HAVEN, MO.

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

13a. FATHER'S NAME JOSEPH SOPH

13b. MOTHER'S MAIDEN NAME WILIMENA GERDING

14. NAME OF HUSBAND OR WIFE JESSE EKEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO NONE

16. SOCIAL SECURITY NO. NONE

17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. VIOLET GARDNER ST. LOUIS, MO.

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) Cerebral hemorrhage
ANTECEDENT CAUSES
DUE TO (b) Cerebral arteriosclerosis
DUE TO (c) Generalized arteriosclerosis
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
24 hrs
Many years
Many years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 331x

20. AUTOPSY? YES NO

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) (Minute)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 21, 1957, to Sept 24, 1957, that I last saw the deceased alive on Sept 24, 1957, and that death occurred at 2:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James B Jones M.D.

23b. ADDRESS 337 N. Lockwood Webster Groves 19, Mo.

23c. DATE SIGNED 9-26-57

24a. BURIAL CREMATION REMOVAL (Specify)

24b. DATE 9/27/57

24c. NAME OF CEMETERY OR CREMATORY ZION CEMETERY

24d. LOCATION (City, town, or county) (State) UNION MO.

DATE REC'D BY LOCAL REG. 9-26-57

REGISTRAR'S SIGNATURE Herbert R Donko MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ernest L. Olthmann Union Mo.

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

NOV 25 1957

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..... *Isaac L. Ottmann*.....

Licensed Embalmer No. *4054*.....

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