

FILED DEC 10 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41843**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10893**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town or townships) <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>27 Homer G. Phillips</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <b>4004 Fairfax</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Zenobia</b> b. (Middle) c. (Last) <b>Clayton</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 12, 1957</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>May 4, 1886</b>		9. AGE (In years last birthday) <b>71</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Okalone, Mississippi</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					

13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Emma Dobbs 719 King</b>	

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) <b>Intertrochanteric Fracture of Left Hip</b> ANTECEDENT CAUSES (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> <b>Suffered in fall at Home</b> DUE TO (c) <b>October 5, 1957.</b>			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			

21a. ACCIDENT SPECIFIC HOME OR OTHER (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Mo</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>10 5 57 ? m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>OOD</b>	

22. I hereby certify that I attended the deceased from **10/19/57** to **11/12/57**, 19**57**, that I last saw the deceased alive on **11/12/57**, and that death occurred at **6:57 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Patrick Taylor Carroll</b>		23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>11.14.57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>11/16/57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	
24d. LOCATION (City, town, or county) (State) <b>Berkley, Missouri</b>					

DATE REC'D BY LOCAL REG. <b>NOV 14 57</b>		REGISTRAR'S SIGNATURE <b>Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W. B. Koonce 1221 N. Grand Blvd.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

**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 *Clarence Green*.....

Licensed Embalmer No. *7755*

P. O. Address *1221 Green*.....

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.