

XC-1487 896
SL 1694 FILED MAR 10 1958
Registration District No. _____

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007088
STATE FILE NUMBER
318 Primary Registration District No. 1003 Registrar's No. 1560

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Handwritten: new 8 c/c

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		c. CITY OR TOWN MARYLAND HEIGHTS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) RT. #1, BOX 109	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS C. CLARK		4. DATE OF DEATH Month Day Year FEBRUARY 10, 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/80
9. AGE (In years of last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAM FITTER	11. BIRTHPLACE (City and state or country) BEREA, OHIO
12. CITIZEN OF WHAT COUNTRY? USA		13. NAME OF HUSBAND OR WIFE ANNA MAE	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW-1		15. SOCIAL SECURITY NO. 498-10-6684	
16. INFORMANT VA HOSP. RECORDS, ST. LOUIS, MO.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO (b) CEREBRAL ARTERIOSCLEOSIS DUE TO (c) - - - - - 331x - - - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - - - - -			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS UNKNOWN
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> NONE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. Attended the deceased from 2/6/58 to 2/10/58 and last saw him alive on 2/10/58 Death occurred at 4:10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Handwritten: Dr. F. H. ...</i>		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 2/10/58			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2/12/1958	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri.
24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar		25. DATE RECD. BY LOCAL REG. FEB 10 '58	26. REGISTRAR'S SIGNATURE <i>Handwritten: Carl Smith mo</i>

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 H. Murr*

Licensed Embalmer No. *4011*

P. O. Address *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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.