

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041407

STATE FILE NUMBER

DEC 15 1958

Registration District No.

318

Primary Registration District No.

1008

Registrar's No.

11536

300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Webster Groves</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hosp.</u>		Length of stay in lb <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>672 Atalanta</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>M.</u> Last <u>CLAWSON</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1883</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Louis Wagner</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Bailey</u>		14. NAME OF HUSBAND OR WIFE <u>Roy L. Clawson</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>None</u>	17. INFORMANT Address <u>Ruth C. Smith, 28 Holly Drive</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis and arterial hypertension 2 years</u>					
DUE TO (c) <u>331X</u>					
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>None</u>			
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. I attended the deceased from <u>11-22-55</u> to <u>11-30-58</u> and last saw <u>her</u> alive on <u>11-30-58</u> Death occurred at <u>7:40 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>H. B. Aldrich M.D.</u>			22b. ADDRESS <u>19 E. Lockwood Ave., Webster Groves 19, Mo.</u>		22c. DATE SIGNED <u>12-1-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-2-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hiram Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR <u>Parker-Aldrich</u>		ADDRESS <u>Webster Groves</u>		25. DATE REG. BY LOCAL REG. <u>DEC 1 - '58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>mjb.</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ledie Welch*
Licensed Embalmer No. *4395*
P. O. Address *Walter Street*

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.