

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006982

STATE FILE NUMBER
Registration District No. 2 Primary Registration District No. 1217

FILED FEB 17 1959

300
-57
394
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1309A South 8th		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1309 A. So. 8th St.
3. NAME OF DECEASED (Type or print) First Middle Last Nora Clark			4. DATE OF DEATH Month Day Year January, 30 1959
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY House Wife	9. AGE (In years last birthday) Months Days Hours Min. 43
11. BIRTHPLACE (City and state or country) Colombio Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE John Clark
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) no		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address John Clark 1309 a South 8th Street
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			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 331+			
DUE TO (c)			
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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. I attended the deceased from death occurred at 1145 P. and last saw her alive on			
22a. SIGNATURE (Degree of title) Nora Clark	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 2/4/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 6, 1959	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) Jefferson Br. Mo.
24. FUNERAL DIRECTOR E.B.Koonce Mortuary		ADDRESS 1221 N. Grand	25. DATE RECD. BY LOCAL REG. FEB 4 '59
		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Grand*

Licensed Embalmer No. *4755*

P. O. Address *221 N Grand*

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.