

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023419

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1774

STATE FILE NUMBER

FILED JUL 5 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cool Valley</u>		Length of stay in 1b <u>38 Days</u>	c. CITY OR TOWN <u>Overland</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hill Top Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10734 Wurdack</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>B.</u> Last <u>Clippard</u>			4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1961</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>10/27/1905</u>	9. AGE (last birthday) <u>55</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Edina Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Burch</u>	13b. MOTHER'S MAIDEN NAME <u>Ella Lorey</u>	14. NAME OF HUSBAND OR WIFE <u>David Clippard</u>
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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>Unknown</u>	17. INFORMANT Address <u>David Clippard 10734 Wurdack</u>
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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 vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N- <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m.	Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <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>May 18 - 1961</u> to <u>June 24 - 1961</u> and last saw her <u>live on June 24 - 1961</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>John G. McJannet MD</u>	22b. ADDRESS <u>5014 Thekla Dr</u>	22c. DATE SIGNED <u>6/24/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/27/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR <u>Collier Mortuary, St. Ann, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-26-61</u>	26. REGISTRAR'S SIGNATURE <u>John G. McJannet MD</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Faint, mostly illegible text at the top of the page, possibly containing identification or administrative information.

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 Sheldon Collier

Licensed Embalmer No. 3382
P. O. Address St. Ann

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.