

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-034143

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8962

FILED OCT 13 1961

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY		c. CITY OR TOWN Indianapolis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. AT St. Louis City Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4105 N. Desmond			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Paul Middle A. Last Clark, III				4. DATE OF DEATH Month Sept. Day 26, Year 1961		5. SEX Male		6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/12/56	9. AGE (last birthday) 4	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) Wilmington, Ind.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Paul A. Clark, Jr.				13b. MOTHER'S MAIDEN NAME Sylvia			14. NAME OF HUSBAND OR WIFE -----						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Capt. Paul A. Clark, Sr.		Address 4104 Hartford					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Compound comminuted fracture of the frontal skull, Frontal bone, nasal bone, all facial bones and the base of the skull; Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ruptured when struck by car operated by one Helen Brennan, in front of about 4130 Hartford, about 6:15 P.M., September 26, 1961. DUE TO (c) accident										INTERVAL BETWEEN ONSET AND DEATH			
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 type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) See above									
20c. TIME OF INJURY Hour 6:15 a.m. p.m. Month, Day, Year 9-26-61		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 16 street		20f. CITY, TOWN, OR LOCATION St. Louis, Mo		COUNTY		STATE			
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Paul A. Clark, Sr.</i>						22b. ADDRESS 1300 Clark			22c. DATE SIGNED 9-28-61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept. 28, 1961		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) Anderson,		(State) Indiana					
24. FUNERAL DIRECTOR WACKER-HELDERLE-3634 Gravois Ave.					25. DATE RECD. BY LOCAL REG. SEP 28 1961		26. REGISTRAR'S SIGNATURE <i>Neal Smith M.D.</i>						

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

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 Phonice M. Billo

Licensed Embalmer No. 4375

P. O. Address Louis 23 Me

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.