

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045318

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11825**

STATE FILE NUMBER

FILED DEC 5 1963

VS 300	DATE-AMENDED
Rev. 4/59	
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2 <b>4019</b>	
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<b>74</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Length of stay in 1b <b>3 mo</b>	c. CITY OR TOWN <b>Creve Coeur</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Johns Hosp</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>12136 Olive St Rd</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Michael J Clarke</b>			4. DATE OF DEATH Month Day Year <b>Nov 29 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/8/1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Catholic</b>	9. AGE (last birthday) <b>71</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Patrick Clarke</b>		13b. MOTHER'S MAIDEN NAME <b>-- Lynch</b>	
14. NAME OF HUSBAND OR WIFE <b>---</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>St Louis Mo</b> <b>Sr Michael Joseph 1354 Tamm</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>491x</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis heart Disease</b>			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 - 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. 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 <b>11-26-62</b> to <b>11-29-63</b> and last saw him alive on <b>11-28-63</b> Death occurred at <b>8:35 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John McLean MD</b>		22b. ADDRESS <b>4401 Hampton</b>	22c. DATE SIGNED <b>29 Nov 63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/2/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	23d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>
24. FUNERAL DIRECTOR <b>Ortmann F Home 9222 Lackland Overland Mo</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 30 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loed Smith. M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

PL 107-110

FILED IN

**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 Al C Ostmann

Licensed Embalmer No. 3478

P.O. Address \_\_\_\_\_

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.