No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35804 35803

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 4837 Bessie Ave. (If rural, give location) 9
(e) Citizen of foreign country? (Yes or No) 7
If yes, name country

3. (a) PRINT FULL NAME CLARENCE HAND

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frieda Hand

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased May (Month) 23 (Day) 1883 (Year)

8. AGE: Years 64 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Paris (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Elevator Operator

11. Industry or business Terminal R.R.

MOTHER FATHER

12. Name Hiram Hand

13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER

14. Maiden name Jeanette Simon

15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. Frieda Hand
(b) Address 4837 Bessie Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-22-47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) OCT 22 1947 (Date received local registrar) J. T. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22 year 1947 hour 5 minute 10 A.M.

21. I hereby certify that I attended the deceased from Oct 10, 1947, to Oct 22, 1947 that I last saw him alive on Oct 22 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac failure.	
Due to: Arteriosclerotic heart disease	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy none	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature H C Bradley (M. D. or other)
Address Barnes Hospital Date signed 10/22/47

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed..... J. Allen Daniel

Licensed Embalmer No. 4088

P. O. Address..... Tampa

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 this body is not embalmed, fact should be so stated above.