

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22074**

FILED JUN 20 1946

Primary Registration District No. **1003**

Registrar's No. **4588**

1. PLACE OF DEATH:

(a) County **St. Louis Mo.**
(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 **6 days** (Specify whether years, months or days)
In this community years, months or days

3. (a) PRINT FULL NAME **LAUREL CLARENCE PACE**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Letha** 6. (c) Age of husband or wife if alive **43** years
7. Birth date of deceased **August 8 1903**
(Month) (Day) (Year)

8. AGE: Years **42** Months **9** Days **23** If less than one day hr. min.

9. Birthplace **Koshkonong Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Butcher**

11. Industry or business

12. Name **Clarence E. Pace**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Olive Stuart**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Leon Pace**

(b) Address **Alton, Ill.**

17. (a) **Burial** (b) Date thereof **6-3-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **West Plains, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **JUN 3 1946** (b) **J. F. Braddock**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Arkansas** (b) County **Baxter**
(c) City or town **Mountain Home**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **31**
year **1946** hour **11:00** minute **P.M.**

21. I hereby certify that I attended the deceased from **May 25**, 1946, to **May 31**, 1946,
that I last saw him alive on **May 31**, 1946,
and that death occurred on the date and hour stated above.
Immediate cause of death

Bronchopneumonia - Lobar
Pneumonia
Due to **33XXXXX**
Due to **TULAREMIA**

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy **Large liver, large spleen**

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature **JR Bradley** (M. D. certificate)
Address **Barnes Hospital** Date signed **5/31/46**

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.....

John Agonoshin

Licensed Embalmer No. *2398*

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