

No. 2  
5-43  
17-30  
X36671

FILED DEC 18 1946  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County Saint Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Res. - 7520 Byron Place  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Clayton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7520 Byron Place  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Clara Lydia Wagon

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife H.W. Wagon 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 12 - 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 7 28 hr. \_\_\_\_\_ min.

9. Birthplace Maid Stone, Kent England  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name George Thomas Pearce

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

14. Maiden name Angela Jupe

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

16. (a) Informant Winifred Carr Stumpe

(b) Address 7520 Byron Place

17. (a) Cremation (b) Date thereof 12/12/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director C. R. Lupton & Sons  
(b) Address 7233 Delmar Blvd

19. (a) 12-12-46 (b) Ruth Allen MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 10 th  
year 1946 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from 1941  
\_\_\_\_\_, 19\_\_\_\_, to 12-10, 1946  
that I last saw her alive on 12-3-46, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular renal disease

Due to 131B

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
(c) Means of injury \_\_\_\_\_

23. Signature Ruth Allen MD (M. D. or other) MD  
Address 5074 N. Union Date signed 12-11-46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

91  
2  
3  
5

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

5074 No. Union  
Mo. 1030  
9 to 12 A.M.

DEC 17 1945

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 *Clarence H. Murray*

Licensed Embalmer No. *4011*

P. O. Address *St. Louis, Mo.*

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.