

FILED DEC 22 1947

1003

Registration District No. **318** Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town ST LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
FITMIN DES LOGE Hosp. - 0  
(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

3. (a) PRINT FULL NAME

CLEMMIE EAST GARNER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex FE / 5. Color or race WHITE  
6. (a) Single (widowed) married, divorced \_\_\_\_\_

6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased April 25 1870  
(Month) (Day) (Year)

8. AGE: Years 77 Months 7 Days 12  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace TROY MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business OWN HOME

MOTHER FATHER

12. Name SAMUEL T. EAST

13. Birthplace LINCOLN Co. MO  
(City, town, or county) (State or foreign country)

14. Maiden name LUCIEMMA AMELIA WHEELER

15. Birthplace LINCOLN Co. MO  
(City, town, or county) (State or foreign country)

16. (a) Informant EARNEST CARTER

(b) Address COLUMBIA MO

17. (a) BURIAL (b) Date thereof DEC 10 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation TROY Cem. Troy, Mo.

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) DEC 10 1947 (Date received local registrar)

[Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 7  
year 1947 hour 7 minute 50 P.M.

21. I hereby certify that I attended the deceased from 22 Sept 1947 to 7 Dec 1947  
that I last saw her alive on 7 Dec 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy  
Due to Cerebral arteriosclerosis

Duration  
Immediate  
Unknown

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy No autopsy

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 [Signature] (M. D. or other) MO  
Address Fitmin Desloge Hosp Date signed 7 Dec 47

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

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**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.....

*Joseph J. Marsh*  
.....  
Licensed Embalmer No. *3932*  
.....

P. O. Address.....

*Troy, 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.**