

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39096

State File No. _____

Registrar's No. **10144**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6206 Vermont		d. STREET ADDRESS (If rural, give location) 6206 Vermont	

3. NAME OF DECEASED (Type or Print) a. (First) Clarence C. Hancock	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Nov. 14, 1951
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct. 31, 1900	9. AGE (In years last birthday) (If under 1 year: Months) (If under 12 months: Days) (If under 12 hours: Hours) (If under 15 min.: Min.) 51
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY no	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? 0
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13a. FATHER'S NAME William Hancock	13b. MOTHER'S MAIDEN NAME Elizabeth Crook	14. NAME OF HUSBAND OR WIFE Marcella Hancock
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) non	16. SOCIAL SECURITY NO. non	17. INFORMANT'S SIGNATURE OR NAME Marcella Hancock	ADDRESS 6206 Vermont
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days May 1946
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia Hypostatic ANTECEDENT CAUSES Lymphatic Leukemia DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION Nov	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 2040
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22. I hereby certify that I attended the deceased from **May 10, 1946**, to **Nov 17, 1951**, that I last saw the deceased alive on **May 17, 1951**, and that death occurred at **10a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. J. ...	23b. ADDRESS 2767 Harrison St	23c. DATE SIGNED 1-14-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-17-51	24c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. NOV 14 1951	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home	ADDRESS 6322 S. Grand Blvd.
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

[Faint, illegible handwritten text]

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 _____

.....
working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed *David Van Fossan*

Licensed Embalmer No. *4242*

P. O. Address *6322 So. Grand*

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.