

FILED OCT 18 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35002**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **212**

1. PLACE OF DEATH a. COUNTY <b>St Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Charles</b>		c. LENGTH OF STAY (In this place) <b>59 yrs</b>	c. CITY OR TOWN <b>St Charles</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Joseph Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <b>1600 Tompkins St</b>		0923	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Clara</b>	b. (Middle)	c. (Last) <b>East</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct 14 1954</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 28 1883</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>16</b>	IF UNDER 24 HRS. Hours <b>0</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Troy Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Peter Presley</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Calloway</b>	14. NAME OF HUSBAND OR WIFE <b>Arthur East</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Arthur East</b>	ADDRESS <b>1600 Tompkins St, St Charles</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Carcinomatosis</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 <b>none</b>	19b. MAJOR FINDINGS OF OPERATION <b>none</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	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?
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22. I hereby certify that I attended the deceased from **December, 1953**, to **Oct 14, 1954**, that I last saw the deceased alive on **Oct 14, 1954**, and that death occurred at **12:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Dar L. Randall, M.D.</b>	23b. ADDRESS <b>2707 N. 5th St. St. Charles Mo.</b>	23c. DATE SIGNED <b>Oct. 15, 1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct. 15 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Troy Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Troy Mo.</b>
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DATE REC'D BY LOCAL REG <b>Oct 16 1954</b>	REGISTRAR'S SIGNATURE <b>Fannie Hammett</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm C. Hammett</b>	ADDRESS <b>Hammett Exchangers</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Charles M. Bilko*.....

Licensed Embalmer No. *437*.....  
P. O. Address *St. Charles*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.