

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35235**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9315**

|                                                                                                       |  |                                                                                                                                                  |                              |
|-------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                        |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY <b>Bollinger</b> |                              |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>St. Louis, Mo.</b> |  | c. LENGTH OF STAY (in this place)                                                                                                                | c. CITY OR TOWN <b>Zalma</b> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>                                        |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                |                              |
|                                                                                                       |  | e. STREET ADDRESS (If rural, give location) <b>0.090</b>                                                                                         |                              |

|                                                                                                                      |                               |                                                                                                                    |                                       |
|----------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Willard</b><br>b. (Middle) <b>NMN</b><br>c. (Last) <b>Clubb</b> |                               | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Oct. 12, 1954</b>                                                      |                                       |
| 5. SEX <b>Male</b>                                                                                                   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>                                              | 8. DATE OF BIRTH <b>Oct. 31, 1898</b> |
| 9. AGE (In years last birthday) <b>55</b>                                                                            |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>           |                                       |
| 10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>                                                                        |                               | 11. BIRTHPLACE (City and State or Foreign Country) <b>Zalma, Mo.</b>                                               |                                       |
| 13a. FATHER'S NAME <b>Thomas Clubb</b>                                                                               |                               | 13b. MOTHER'S MAIDEN NAME <b>Belle Sitze</b>                                                                       |                                       |
| 14. NAME OF HUSBAND OR WIFE <b>Eva Clubb, Zalma, Mo.</b>                                                             |                               | 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>Unknown</b>                                                                               |                               | 17. INFORMANT'S SIGNATURE OR NAME <b>Cecil Clubb, Marble Hill, Mo.</b>                                             |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                             |                               | 18. MEDICAL CERTIFICATION                                                                                          |                                       |

|                                                                                                                                                |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                       |  | 18. MEDICAL CERTIFICATION                                                                       |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Monocytic Leukemia</b>                                                         |  | INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>                                                  |  |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  | ANTECEDENT CAUSES                                                                               |  |
| DUE TO (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</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                                                                                                                         |  | 19b. MAJOR FINDINGS OF OPERATION                                                                |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |  | 21a. ACCIDENT SUICIDE HOMICIDE (Specify)                                                        |  |

|                                                                                                        |  |                                                                                          |  |
|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|
| 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) <b>204.2</b>                                           |  | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)                                          |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                                                               |  |

22. I hereby certify that I attended the deceased from **Sept. 28, 1954**, to **Oct. 12, 1954**, that I last saw the deceased alive on **Oct. 12, 1954**, and that death occurred at **1:25 A.M.**, from the causes and on the date stated above.

|                                                                      |  |                                                          |  |
|----------------------------------------------------------------------|--|----------------------------------------------------------|--|
| 23a. SIGNATURE (Degree or title) <b>H. Bradley M. D.</b>             |  | 23b. ADDRESS <b>BARNES HOSPITAL</b>                      |  |
| 23c. DATE SIGNED <b>10/12/54</b>                                     |  | 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> |  |
| 24b. DATE <b>10-13-54</b>                                            |  | 24c. NAME OF CEMETERY OR CREMATORY                       |  |
| 24d. LOCATION (City, town, or county) (State) <b>Lutesville, Mo.</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE                         |  |

|                                             |  |                                                   |  |
|---------------------------------------------|--|---------------------------------------------------|--|
| DATE REC'D BY LOCAL REG. <b>OCT 13 1954</b> |  | REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>   |  |
| 25. FUNERAL DIRECTOR'S SIGNATURE            |  | ADDRESS <b>Hard Funeral Home, Lutesville, Mo.</b> |  |

(Licensed Embalmer's Statement on Reverse Side)

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

9561 11/1/55

OCT 27 1955

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..... *James R. Chapman*  
Licensed Embalmer No. *455*  
P. O. Address *St. Louis*

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.