

FILED JAN 6 1956

STANDARD CERTIFICATE OF DEATH

State File No. 42535  
Registrar's No. 10960

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

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. |  | c. CITY OR TOWN St. Louis  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthonys Hospital                               |  | e. STREET-ADDRESS (If rural, give location) 519 East Davis St.,  |   |

|   |            |             |           |                                |                      |
|---|------------|-------------|-----------|--------------------------------|----------------------|
| 3. NAME OF DECEASED (Type or Print) Clarence F. Reker | a. (First) | b. (Middle) | c. (Last) | 4. DATE OF DEATH Dec. 12, 1955 | (Month) (Day) (Year) |
|---|------------|-------------|-----------|--------------------------------|----------------------|

|             |                        |   |                                 |                                    |                             |                             |
|-------------|------------------------|---|---------------------------------|------------------------------------|-----------------------------|-----------------------------|
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Div. | 8. DATE OF BIRTH Sept. 10, 1898 | 9. AGE (In years last birthday) 57 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|-------------|------------------------|---|---------------------------------|------------------------------------|-----------------------------|-----------------------------|

|   |                                   |   |                                   |
|---|-----------------------------------|---|-----------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Mgr. Apex Eng. Co. | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. | 12. CITIZEN OF WHAT COUNTRY? USA. |
|---|-----------------------------------|---|-----------------------------------|

|                               |   |                                  |
|-------------------------------|---|----------------------------------|
| 13a. FATHER'S NAME Geo. Reker | 13b. MOTHER'S MAIDEN NAME Justina Zinselmeier | 14. NAME OF HUSBAND OR WIFE none |
|-------------------------------|---|----------------------------------|

|  |   |                              |  |                                    |
|--|---|------------------------------|--|------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If yes, give war or dates of service) none | 16. SOCIAL SECURITY NO. Unk. | 17. INFORMANT'S SIGNATURE OR NAME Jos. Reker | ADDRESS 519 W. Davis, St. Louis Mo |
|--|---|------------------------------|--|------------------------------------|

|   |  |  |  |   |
|---|--|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Epidemioid Carcinoma of Lung</i>   |  | MEDICAL CERTIFICATION<br><i>Epidemioid Carcinoma of Lung</i> | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 mos.</i> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (c) |  |  |   |
|   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                |  |  |   |

|                               |  |  |
|-------------------------------|--|--|
| 19a. DATE OF OPERATION 9/2/55 | 19b. MAJOR FINDINGS OF OPERATION <i>Inoperable Carcinoma of Left Lung 162x</i> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|-------------------------------|--|--|

|  |  |   |
|--|--|---|
| 27a. ACCIDENT SUICIDE HOMICIDE (Specify) | 27b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 27c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|   |  |                            |
|---|--|----------------------------|
| 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 7/27/55 to 12/12, 1955, that I last saw the deceased alive on 12/11, 1955, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

|  |                            |                           |
|--|----------------------------|---------------------------|
| 23a. SIGNATURE (Degree or title) <i>James C. Vest M.D.</i> | 23b. ADDRESS 634 N. Howard | 23c. DATE SIGNED 12/13/55 |
|--|----------------------------|---------------------------|

|  |                    |  |  |
|--|--------------------|--|--|
| 24a. BURIAL CREMATION REMOVAL (Specify) Burial | 24b. DATE 12-16-55 | 24c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
|--|--------------------|--|--|

|                                      |  |  |   |
|--------------------------------------|--|--|---|
| DATE REC'D BY LOCAL REG. DEC 14 1955 | REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i> | 25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home | ADDRESS 6322 S. Grand Blvd., St. Louis, Mo. |
|--------------------------------------|--|--|---|

(Licensed Embalmer's Statement on Reverse Side)

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

Primary

Dr. James C. Vest  
634 N. Grand Blvd.,  
4 to 5 p.m.

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

Student.....  
Signature of Student Embalmer

Signed *David Lee Lasso*

Licensed Embalmer No. *624*

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.