No. 300
10-48

FILED FEB 26 1957

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 6207

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1309

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

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**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 1day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Peoples Hospital 19

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY: St. Clair
c. CITY OR TOWN: East St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒
e. STREET ADDRESS (If rural, give location): 375 N. 26th Street 32 8120 8

**3. NAME OF DECEASED** (Type or Print)
a. (First): CLARENCE
b. (Middle): LESLEY
c. (Last): GASTON

**4. DATE OF DEATH** (Month) (Day) (Year): February 5, 1957

**5. SEX**: Male 2
**6. COLOR OR RACE**: Negro
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married 1
**8. DATE OF BIRTH**: June 20, 1904
**9. AGE** (In years last birthday): 52 — 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): Teacher
**10b. KIND OF BUSINESS OR INDUSTRY**: Lincoln High School
**11. BIRTHPLACE** (City and State or Foreign Country): Calhoun, Mississippi 1
**12. CITIZEN OF WHAT COUNTRY?**: USA

**13a. FATHER'S NAME**: WILLIAM GASTON
**13b. MOTHER'S MAIDEN NAME**: BELL EDWARDS
**14. NAME OF HUSBAND/OR WIFE**: ETHEL GASTON

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service): NO
**16. SOCIAL SECURITY NO.**: Unknown
**17. INFORMANT'S SIGNATURE OR NAME** ADDRESS: 375 N. 26th Street, E. St. Louis, Illinois

**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.

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of the lung with metastases — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
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.* 163 x

**19a. DATE OF OPERATION**: 3
**19b. MAJOR FINDINGS OF OPERATION**: Carcinoma of lung Inoperable
**20. AUTOPSY?** YES ☐ NO ☒ 2

**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)
**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* 10/10, 1955, *to* 2/5, 1957, *that I last saw the deceased alive on* 2/5, 1957, *and that death occurred at* 3:10 p m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): Chas. R. Kruger M.D.
**23b. ADDRESS**: 1419 Kansas
**23c. DATE SIGNED**: 2/8/57

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal
**24b. DATE**: 2/8/57
**24c. NAME OF CEMETERY OR CREMATORY**: Sunset Garden of Memory
**24d. LOCATION** (City, town, or county) (State): Stookey Township, Illinois

**DATE REC'D BY LOCAL REG.**: FEB 8 '57
**REGISTRAR'S SIGNATURE**: J. Earl Smith M.D. MJB
**25. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Marion E. Officer 2114 Missouri Ave. E. St. Louis, Ill.

(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalm

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Ben H. Baldwin

Licensed Embalmer No. 2420

P. O. Address 721 N. 26th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu 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.