FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33339

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8253

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5201a S Grand Bl. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 5201a South Grand Bl. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Clarence F Chenot
4. DATE OF DEATH Month Day Year: Sept.1,1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/18/1889
9. AGE (In years last birthday): 68 — 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): Ret Machinst
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Waterloo Illinois
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Samuel Chenot
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 489-05-3065
17. INFORMANT Address: Mary Lueckenhoff 5201 S Grand Bl.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma of Prostate
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive + Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 177 X
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from June 1956 to Sept 1, 1957 and last saw her/him alive on ~~Sept 1, 1957~~
Death occurred at 10:45 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): A M Huggins, M.D.
22b. ADDRESS: 634 N. Grand
22c. DATE SIGNED: 9-4-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9/5/57
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem.
23d. LOCATION (City, town, or county) (State): St. Louis County Mo

24. FUNERAL DIRECTOR ADDRESS: Edward Fendler 5611 South Grand Blvd
25. DATE RECD. BY LOCAL REG.: SEP 4 '57
26. REGISTRAR'S SIGNATURE: Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

...ealth, Welfare ...ublic ...ervice

...300 ...1-56

...author, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 49

P. O. Address

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