

FILED NOV 22 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42927

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2809

S. 300  
7. 1-56

Doctor, coroner, 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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kirkwood</u> <u>4723</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Length of stay in lb <u>26 days</u>		d. STREET (If outside, give location) ADDRESS <u>16 Sweetbriar</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>DENSMORE</u> Last <u>HILL</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1892</u>	
9. AGE (In years last birthday) <u>65</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>film distributor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COLUMBIA Pictures</u>		11. BIRTHPLACE (City and state or country) <u>Sullivan, Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>unknown</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW I</u>			
16. SOCIAL SECURITY NO. <u>488-03-3502</u>				17. INFORMANT Address <u>Muriel S. Hill, 16 Sweetbriar</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Bilateral hydro nephrosis</u> DUE TO (c) <u>Prostatic Hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>610X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>4-5 years</u> <u>5 years</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>9:30</u> Month, Day, Year a. m. <u>11/11/57</u> p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Kirkwood (22) Mo</u>		COUNTY <u>Mo</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>10/7/57</u> to <u>11/11/57</u> and last saw <u>her</u> alive on <u>11/11/57</u> . Death occurred at <u>9:30</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Frederic M. Jones MD</u> (Degree or title)				22b. ADDRESS <u>Kirkwood (22) Mo</u>		22c. DATE SIGNED <u>11/12/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE <u>11-12-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA Oak Grove Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
24. FUNERAL DIRECTOR <u>C. R. Lupton &amp; Sons-7233 Delmar</u>				25. DATE RECD. BY LOCAL REG. <u>11-12-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert H. Danks MD</u>	

arc

Dr. Quentin M. Gaines  
109 N. Taylor  
Taylor 2-0035

*Will 11:00 a.m.  
Kirkwood - Mo.*

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 *Arnold W. Schoene*

Licensed Embalmer No. *3865*

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.