

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-007957

STATE FILE NUMBER

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

1862

300

-57

|   |                           |   |   |  |  |
|---|---------------------------|---|---|--|--|
| 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, give TOWNSHIP only)<br>OR TOWN St. Louis  |                           | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |   | c. CITY OR TOWN St. Louis  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br>37 3419 Gasconade  |                           | Length of stay in 1b  |   | d. STREET ADDRESS 2310 922 Park (If outside, give location)          |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Clara Agnes West  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>Feb. 15, 1958 |  |  |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Feb. 15, 1877                   | 9. AGE (In years and birth day)<br>81                                | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Seamstress   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Bear & Fuller  |   | 11. BIRTHPLACE (City and state or country)<br>California             | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                           |
| 13a. FATHER'S NAME<br>Mnk   |                           | 13b. MOTHER'S MARRIAGE NAME<br>Mnk  |   | 14. NAME OF HUSBAND OR WIFE  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>488-01-8425  |   | 17. INFORMANT Address<br>Paul J. Kaveney 705 Olive St.               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) acute broncho pneumonia<br>arteriosclerotic heart disease<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart disease<br>arthrititis-hypertension DUE TO (c) Arthritis - Hypertension |                           |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>7 days<br>?<br>?             |
| 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.)<br>420.0   |   |  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. 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 COUNTY STATE                            |  |
| 21. I attended the deceased from Death occurred at 6:00 A. to 2/15/58 and last saw her alive on 2/12/58   |                           | m on the date stated above; and to the best of my knowledge, from the causes stated.  |   |  |  |
| 22a. SIGNATURE (Degree or title)<br>George T. Mehan M.D.  |                           | 22b. ADDRESS<br>3930 Olive  |   | 22c. DATE SIGNED<br>2/17/58  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 23b. DATE<br>2-18-58  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cemetery               |  |
|   |                           |   |   | 23d. LOCATION (City, town, or county) (State)<br>St. Louis, Missouri |  |
| 24. FUNERAL DIRECTOR<br>Chas. F. Stuart   |                           | ADDRESS<br>1225 Union Blvd.   |   | 25. DATE RECD. BY LOCAL REG.<br>FEB 17 '58                           |  |
|   |                           |   |   | 26. REGISTRAR'S SIGNATURE<br>Paul Smith M.D.                         |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *J. Wm. Banksley* .....

Licensed Embalmer No. *3653*  
P. O. Address *St. Louis 12 Mo.*

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.