

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011620

STATE FILE NUMBER

FILED MAR 19 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 703

300  
1-57

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis.</u>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis.</u>                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Clayton, Mo.</u>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Maplewood</u> <u>4534</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                 |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>  |                                  | Length of stay in lb <u>2 Wks.</u>  | d. STREET ADDRESS (If outside, give location)<br><u>2632 Roseland, Ter.</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Clarence</u> Middle <u>A.</u> Last <u>LUNN</u>   |                                  |   | 4. DATE OF DEATH<br>Month <u>3</u> Day <u>15</u> Year <u>59</u>  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 25, 1900</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>General</u>   | 9. AGE (In years last birthday) <u>58</u><br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min.  |
| 11. BIRTHPLACE (City and state or country)<br><u>Salem, Missouri.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13a. FATHER'S NAME<br><u>Unknown</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   | 14. NAME OF HUSBAND OR WIFE<br><u>Gerene</u>   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><u>No.</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>497-01-8970</u>   | 17. INFORMANT Address<br><u>Clarence A. Lunn, 4357 St. Regina, St. Ann, Mo</u>   |
| 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) <u>Pulmonary Edema &amp; Atelectasis Right Lung</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of Larynx - metastatic</u><br>DUE TO (c) <u>Chronic Cholecystitis</u> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| 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><u>161X</u>   |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>2-23-59</u> to <u>3-15-59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>3-15-59</u><br>Death occurred at <u>6:15</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                                  |   |  |
| 22a. SIGNATURE <u>D. W. Benson</u> (Degree & title) <u>J. M. D.</u>  |                                  | 22b. ADDRESS<br><u>601 So. Brentwood</u>  | 22c. DATE SIGNED<br><u>3-16-59</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  | 23b. DATE<br><u>3-17-59</u>      | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Local Cemetery</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>Salem, Missouri.</u>   |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Albert H. Hoppe 4700 Washington, Blvd.</u>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><u>3-17-59</u>  | 26. REGISTRAR'S SIGNATURE<br><u>John C. Murphy, M.D.</u>   |

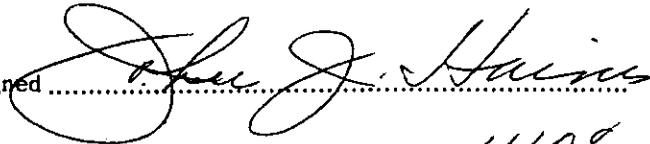
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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  .....  
Licensed Embalmer No. 4408 .....  
P. O. Address Houston .....

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.