

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

FILED JUL 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26752

STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 531 Registrar's No. 1684

| | | | | | | | |
|---|--|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>University City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 4366 |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Res. 6304 Cates</u> | | | Length of stay in 1b <u>years</u> | d. STREET ADDRESS <u>6304 Cates</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>Ford</u> Last <u>Wescoat</u> | | 4. DATE OF DEATH <u>July 2, 1957</u> | | 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 10, 1879</u> | | 9. AGE (In years last birthday) <u>77yrs</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private Practice</u> | | 11. BIRTHPLACE (City and state or country) <u>Vernon Twp. Clanton Co. Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Sabirt F. Wescoat</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Ford</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>277-10-0332</u> | | 17. INFORMANT Address <u>Miss Anne L. Warner 5064a Tholozan</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>Excessive Basal and Squamous</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma entire Right side of face</u> DUE TO (c) <u>and neck</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>191X</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>17yrs</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 Month, Day, Year 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 <u>1948</u> to <u>present</u> and last saw <u>her</u> alive on <u>7/2/57</u> Death occurred at <u>12:00 A.M.</u> on the <u>2</u> day of <u>July</u> 19 <u>57</u> at the <u>home</u> of the deceased; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | 22b. ADDRESS <u>3720 Washington</u> | | 22c. DATE SIGNED <u>7/2/57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>June 5, 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u> | | |
| 24. FUNERAL DIRECTOR <u>Alexander & Sons 6125 Delmar</u> | | | 25. DATE RECD. BY LOCAL REG. <u>7/6/57</u> | | 26. REGISTRAR'S SIGNATURE <u>Herbert R. Donahue</u> | | |

JONSTAD
Dr. Louis F. Pasch
3770 Washington
Je 5 3964
11-1

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 Gas. E. McCulloch

Licensed Embalmer No. 29

P. O. Address 617 52

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.