

FEB MAR 5 - 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County *De Kalb* Registration District No. *258*
Township *Washington* Primary Registration District No. *5360*
City *Clarksdale* St. _____ Ward _____

File No. *6451*
Registered No. *3*

2. FULL NAME

Clamon Grace Babbitt
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Harriet Babbitt*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *12-28-1869*

7. AGE YEARS *70* MONTHS *9* DAYS *98* If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Farmer*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) *1940* 11. Total time (years) spent in this occupation *45*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

FATHER 13. NAME *Joren Babbitt*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *England*

MOTHER 15. MAIDEN NAME *Mary Pettie*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

17. INFORMANT (ADDRESS) *Mrs Clayton Babbitt Clarksdale, Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Pleasant Grove* DATE *2-7-1940*

19. UNDERTAKER (ADDRESS) *John Brann Clarksdale, Mo*

20. FILED *Feb 9 1940* *Mrs C M Davis* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2/6*, 19*40*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 1st*, 19*40*, to *Feb 3rd*, 19*40*

I last saw him alive on *Feb 3rd*, 19*40* Death is said

to have occurred on the date stated above, at *H. A. M.*

The principal cause of death and related causes of importance were as follows:

myocardial degeneration Date of onset *3/29/39*

Other contributory causes of importance: *Brachycardia*

Name of operation *none* Date of _____

What test confirmed diagnosis? *clin* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify _____

(Signed) *O. F. Parham* I. M. D.

(Address) *Clarksdale, Mo.*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 111
District File Number
Date Filed

RECEIVED

District Health Officer No. 111

District File Number 340-197

Date Filed MAR 1 1940

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MAR 1 1940
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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6457**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **258**

Primary Registration District No. **3360**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **DeKalb**
 (b) City or town **Washington** **Texas**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Almon Jerome Babbitt**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **12 28 1861**
(Month) (Day) (Year)

8. AGE: Years **70** Months **1** Days **8** If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **2/19 1940** (b) **Mrs. C. M. Davis**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **De Kalb**
 (c) City or town **Rural**
(If outside city or town limits write "RURAL")
 (d) Street No. **3 mi NE of Clarksdale**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

20. MEDICAL CERTIFICATION

20. DATE OF DEATH Month **2** day **6**
 year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
 While at work? _____
(c) Means of injury

23. Signature **D. L. Perkins** (M. D. or other) _____
 Address **Clarksdale, Miss**

SUPPLEMENTARY

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