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.

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

PLACE OF DEATH

County: Clinton

Township: _____ or Village: _____ or City: Gower, (NO. _____ St.; _____ Ward)

Registration District No. 205 — File No. 7901

Primary Registration District No. 4123 — Registered No. 1

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John David Clay

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

DATE OF BIRTH: Nov. 22, 1837 (Month) (Day) (Year)

AGE: 76 yrs. 3 mos. 4 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Minister
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS

NAME OF FATHER: William Clay.

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky.

MAIDEN NAME OF MOTHER: Sarah Collier

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs J. D. Clay,

(ADDRESS): Gower Mo.

Filed Mch 4, 1914. L. D. Reynolds REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb 26, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Past fifty years, 191__, to ___, 191__, that I last saw him alive on Feb 26, 1914, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis and Cystitis

About (Duration) 5 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) L. F. Stuart M. D.

Feb 27, 1914 (Address) Gower

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Gorham Cemetery

DATE OF BURIAL: Mch 1, 1914

UNDERTAKER: Joe M. McCormon

ADDRESS: Edgerton Mo.

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. .... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ....., 1..... (Year) (Day)

AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ...., 191..... , ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191..... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory ..... (SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

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.