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

PLACE OF DEATH

County: Marion

Township: Round Grove
or
Village:
or
City: (NO. St.: Ward)

Registration District No. 551 File No. 2433

Primary Registration District No. 5744 Registered No. 3 third

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

FULL NAME Claudie Claybrook

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: June (Month) 30 (Day), 1895 (Year)

AGE: 20 yrs. 6 mos. 18 ds.

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

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

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

PARENTS

NAME OF FATHER: John Claybrook

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

MAIDEN NAME OF MOTHER: Lillie Summell

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillie Martin

(ADDRESS) Nelsonville Mo

Filed Jan 19, 1916. J M Crebs
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 18 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 4th, 1915, to Jan 18, 1916, that I last saw him alive on Jan 18, 1916, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) 01 yrs. 1 mos. 21 ds.

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

(Signed) C W Hamlin M. D.

Jan 18, 1916 (Address) Philadelphia Mo.

*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: Providence

DATE OF BURIAL: Jan 19th 1916

UNDERTAKER: W H Leach

ADDRESS: Maysville Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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) .....(Day), *1*.....(Year)

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

.....(Month) .....(Day), *191*.....(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