LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

PLACE OF DEATH
County: Ray
Township: [illegible]
City: Richmond (No. ..... St. ..... Ward)

Registration District No. 744
Primary Registration District No. 3035

File No. 27682
Registered No.

FULL NAME: Beatrice Clay

(a) Residence. No. ..... St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)
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.

V. S. No. 2.

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.

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

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female
4. COLOR OR RACE: Black
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Claud Clay

DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 18 - 1895

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	25	6	14	

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Richmond Mo

NAME OF FATHER: Alex Jourdon

BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ray Co Mo

MAIDEN NAME OF MOTHER: Martha Martin

BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ray Co Mo

INFORMANT: Allen Martin
(Address): Richmond Mo

FILED: Aug 3, 1920 R L Hamilton, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 2 1920

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1916, to Aug 2, 1920, that I last saw he alive on Aug 2, 1920, and that death occurred, on the date stated above, at 7 30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diarrhoea and Enteritis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Tuberculosis of Bowels (duration) 3 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W C Combs, M. D
Aug 2, 1920 (Address) Richmond Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Sunny Slope — DATE OF BURIAL: 8/3 1920

20. UNDERTAKER: Stimell & Co — ADDRESS: Richmond

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,..... St. .....Wa

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19
that I last saw h..... alive on....., 19....., an
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.....

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....,
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, s (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIA
20. UNDERTAKER	ADDRESS