

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

Do not use this space.

1. PLACE OF DEATH

County Clay
Township Gallatin
City Linden No. _____

Registration District No. 197
Primary Registration District No. 5276

File No. 30355
Registered No. 54
St. _____ Ward _____

2. FULL NAME

Russell Clements
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 17-1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
42 9 4

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

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

10. NAME OF FATHER B. M. Clements

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

12. MAIDEN NAME OF MOTHER Mollie

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

14. INFORMANT B. M. Clements
(Address) North Kansas City, Mo

15. FILED 9/23, 1929 WPA REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

by lung burned in Automobile
accident - on State Highway
2.10.29 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Causes Car
(duration) 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. L. Moore

9/21, 1929 (Address) Liberty 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill, KC Mo DATE OF BURIAL 9/23/29

20. UNDERTAKER Wortman & Co ADDRESS Mo KC

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.

24
23
6
1

Y. COAST DISTRICT

1940

1940



1940

1940

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

~~30250~~

1. PLACE OF DEATH

County Clay
Township Yallatin
City Linden Mo. (No. _____)

Registration District No. 197
Primary Registration District No. 5276

File No. _____
Registered No. 54
St. _____ Ward _____

2. FULL NAME

Russell Beal Clements

(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 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 21 1929

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 17 1886

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 9 4

Intermittent Burning and Burning pains to death in the Cox (Corticoid)

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Nutrina Milk Co. K.C. Mo.
(c) Name of employer no

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) no

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

10. NAME OF FATHER B. M. Clements

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) no

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER Mollie

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. L. Myerson Coroner, M. D.
10/26 1929 (Address) Liberty, Mo - Clay Co.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) no

*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.

14. INFORMANT B. M. Clements
(Address) North K. M. Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill, K.C. Mo DATE OF BURIAL 9/28/29

15. FILED _____ 19____ REGISTRAR

20. UNDERTAKER Morton B. No. K.C. Mo ADDRESS _____

WRITE "PAIN" WITH UNFADING INK--THIS IS A TERM 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.

S. 30355