

24 1931

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

Do not use this space.

5258  
57558

1. PLACE OF DEATH

County Harrison  
Township Bethany  
City Bethany (No. 5)

Registration District No. 334  
Primary Registration District No. 4197

File No. 57558  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Frances May Clinkinbeard

(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-15-1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
56 9 12

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work House 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 Wm Baldwin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Do not know

12. MAIDEN NAME OF MOTHER Sarah Cooper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Do not know

14. INFORMANT Sperton Clinkinbeard (Address) Bethany Mo

15. FILED 3/10 1931 WJ Harned REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-27-1931

17. I HEREBY CERTIFY, That I attended deceased from Feb 27 1931 to Feb 27 1931 that I last saw him alive on Feb 27 1931, and that death occurred, on the date stated above, at Bethany Mo A. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia  
108  
95R (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Heart complaint (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_ (Signed) J. H. Boyles, M. D.  
2-28, 1931 (Address) Bethany 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 Antioch Cemetery DATE OF BURIAL 3-1-1931

20. UNDERTAKER S. M. Haas ADDRESS Bethany Mo

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**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Harrison Registration District No. 334 File No. ....  
 Township ..... Primary Registration District No. 4197 Registered No. ....  
 City Bethany (No. ....) St. .... Ward)

**2. FULL NAME**

Frances May Clinkenbeard  
 (a) Residence, No. .... St. .... Ward. .... (If nonresident give city or town and State)  
 (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.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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)

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 3/10 1931 W. J. Starnes REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/27 1931

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 .....

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Pneumonia  
Lobar Pneumonia  
 (duration) ..... yrs. .... mos. .... ds.  
 CONTRIBUTORY (SECONDARY) Heart Complaint  
 (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)....., M. D. , 19 (Address)

\*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

**SUPPLEMENTARY**

PARENTS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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