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

Do not use this space.

12943

1. PLACE OF DEATH
County Greene — Registration District No. 317 — File No.
Township Pondreek — Primary Registration District No. 5437 — Registered No.
City Republic R.F.D. (No. ..... St. ..... Ward)

2. FULL NAME Ruth May Clayton
(a) Residence. No. Greene Co Republic R.R.1 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. 10 How long in U.S., if of foreign birth? yrs. mos. ds.

3

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) - Born 3-24-33

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
~~[illegible]~~			10	

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) Greene Co
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Lou Clayton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lawrence Co
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Katy McClelland
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Greene Co
(STATE OR COUNTRY)

14. INFORMANT Lou Clayton
(Address) Republic, Mo. R.R. 1

15. FILED 4/4, 1933 V. W. Shover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 4 — 1933

17. I HEREBY CERTIFY, That I attended deceased from birth March 24, 1933, to May 4 —, 1933 that I last saw her alive on May 4 —, 1933, and that death occurred, on the date stated above, at 5:00 a.m.

151 THE CAUSE OF DEATH* WAS AS FOLLOWS:

158 Premature Birth

159 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Could not take nourishment (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? no
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) [illegible] M.D.
, 19 (Address) Republic Mo Block 1 Lot 2

*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: Prickett Cemetery — DATE OF BURIAL: 4/4 1933

20. UNDERTAKER: R. E. Thurman — ADDRESS: Republic, Mo.

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.

MAY 22 1933

S-12948