

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 25 1934

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

Do not use this space.

1. PLACE OF DEATH

County *Buchanan*

Registration District No. *85*

Township

Primary Registration District No. *1001*

City *St. Joseph*

(No. *St. Joseph's Hosp.*)

File No. *11927*

Registered No. *309*

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Clyde Davis Todd*

(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. \_\_\_\_\_

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

*Ruth Todd*

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

*10-7-1886*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

*47*

*5*

*25*

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

*Dentist*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

*Stover Mo*

MOTHER FATHER

13. NAME

*Hutton J. Todd*

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

*Centuria Mo*

15. MAIDEN NAME

*Mathie Hughes*

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

*Verdeles Mo*

17. INFORMANT (ADDRESS)

*Mrs Ruth Todd*

18. BURIAL, CREMATION, OR REMOVAL

PLACE

*Stover Mo*

DATE

*4-4-34*

19. UNDERTAKER (ADDRESS)

*Campbell Funeral Home*

*Marxville Mo*

20. FILED

*April 2, 1934*

*John A. Bender*

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 2, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *March 24*, 1934, to *April 2*, 1934

I last saw him alive on *April 2*, 1934. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

*Pulmonary Embolism*

Date of onset *4-2-34*

Other contributory causes of importance:

*Myocardial degeneration*

*6. 1933*

Name of operation *None*

Date of \_\_\_\_\_

What test confirmed diagnosis *Laboratory & Physical*

Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify \_\_\_\_\_

(Signed) *J. H. Ryan*

\_\_\_\_\_, M. D.

(Address) *St. Joseph Mo*

