

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

Do not use this space.

26483

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **ST. LOUIS, Mo.**

(No. **3511 N. IOWA, AVE.**)

File No. ....

**6645**

Registered No. ....

St. .... Ward)

**2. FULL NAME DECIE-ALICE-CLAYBORNE**

(a) Residence, No. 3511 N. Iowa Ave. 24 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Amey Clayborne</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>June 22, 1869</i>		
7. AGE	YEARS <i>25</i>	MONTHS <i>0</i>
	DAYS <i>12</i>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Housewife</i>	
	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	

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 4<sup>th</sup>, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *July 1*, 1934, to *July 4*, 1934.

I last saw him alive on *July 4*, 1934. Death is said to have occurred on the date stated above, at *5:45* p. m.

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

*1911*  
*1911*  
*Branchial Pneumonia*  
*Heat Prostration*

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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) *James M. Hawen*, M. D.

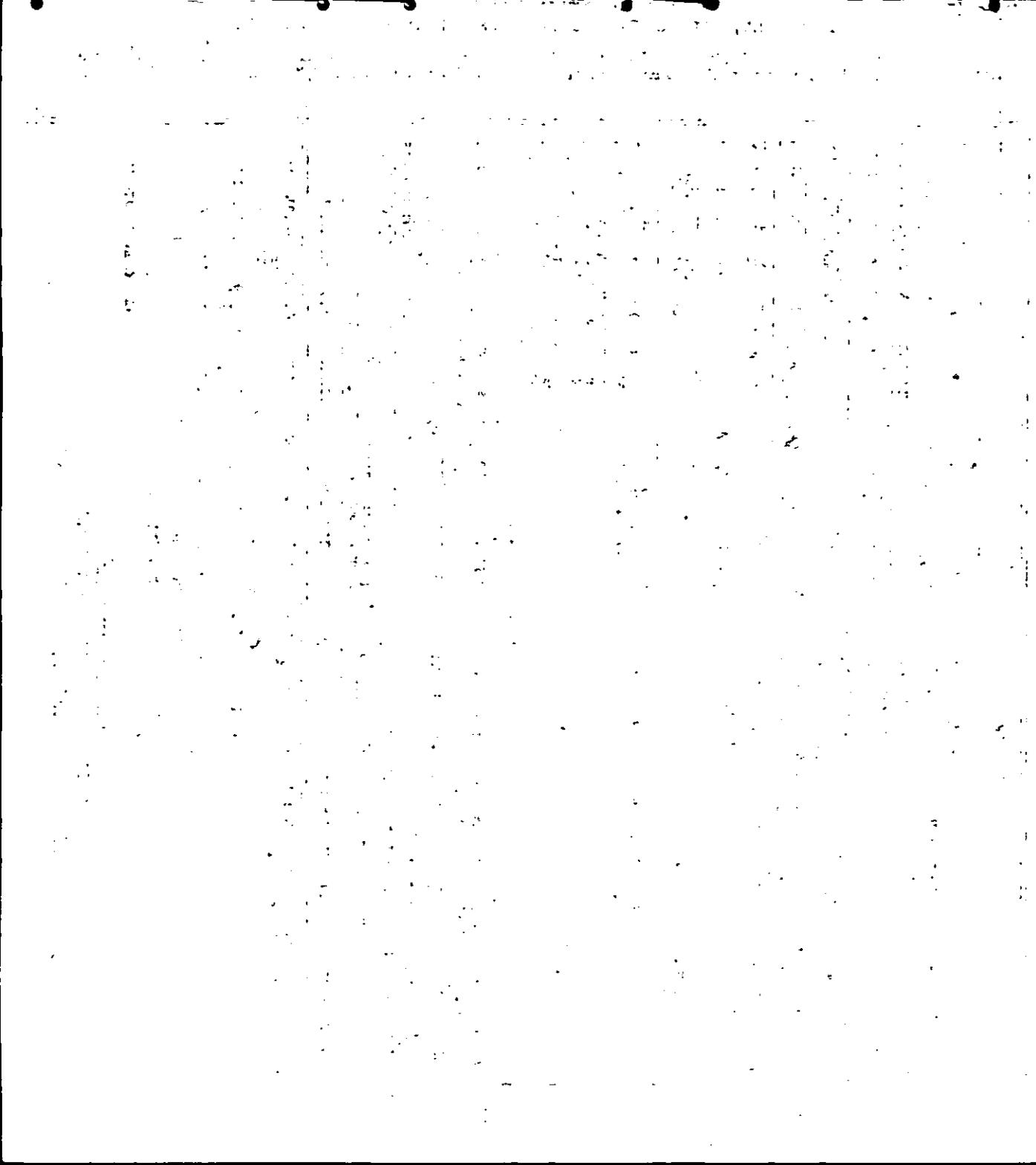
(Address) *2025 S. Jefferson*

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>
	13. NAME <i>BURL CUNNINGHAM</i>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>
	15. MAIDEN NAME <i>MARY-ANN-MILLER</i>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Indiana</i>
	17. INFORMANT <i>NORMA CLAYBORNE</i> (ADDRESS) <i>3511 N. Iowa</i>
	18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Bonne Terre</i> DATE <i>July 7, 1934</i>
	19. UNDERTAKER <i>W. H. McLaughlin</i> (ADDRESS) <i>2301 Lafayette</i>
	20. FILED 19..... Registrar.....

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.

AUG 15 1934



#2 St. Louis.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
WASHINGTON

E. T. McGaugh, M. D.,  
Special Agent,  
Jefferson City, Mo.  
6647.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Decie Alice Clayborne  
Who died at \_\_\_\_\_ on July - 4 - 1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex F Color or race W ~~Single, married, widowed or divorced:~~ \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: \_\_\_\_\_

Other contributory causes of importance \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

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

Name of physician \_\_\_\_\_

Address of physician \_\_\_\_\_

(Signature of Registrar J. J. Bredeck 8-29-34)

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 791

Very truly yours,

Primary Reg. Dist. No. 1003

E. T. McGaugh, M.D.  
Special Agent. R

26483