

NOV 24 1939

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

36045
Do not use this space.

1. PLACE OF DEATH *2*

(a) County *Greene* Registration District No. *316*

(b) Township *1* Primary Registration District No. *4191* Registered No. _____

(c) City *Ash Grove* (d) Street No. _____ St. _____

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *250* *Clara B Hixon*

(a) Residence, No. *Ash Grove Mo.* St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *7-22-1903*

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

36 26 9 25

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

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

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation *1*

12. BIRTHPLACE (CITY OR TOWN) *Ash* (STATE OR COUNTRY) *0*

FATHER 13. NAME *William F Hixon*

14. BIRTHPLACE (CITY OR TOWN) *Dade Co.* (STATE OR COUNTRY) *Mo.*

MOTHER 15. MAIDEN NAME *Georgia Boner*

16. BIRTHPLACE (CITY OR TOWN) *Harrison Co.* (STATE OR COUNTRY) *ky.*

17. INFORMANT *Boyer Hixon* (ADDRESS) *Ash Grove Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE: *Ash Grove* DATE _____ 19 _____

19. FUNERAL DIRECTOR (NAME) *Frederick Morrison* (ADDRESS) *Ash Grove Mo.*

20. FILED *Oct-19 1939* *Mrs. Leonard Jones* *Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 17 1939*

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him *dead* *Oct 17*, 19____ *31* Death is said to have occurred on the date stated above, at *6:30 a. m.*

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

Carcinoma larynx

Date of onset *2.5 years*

Other contributory causes of importance: *H7*

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? _____

If so, specify _____

(Signed) *Robert White* M. D.

2888 (Address) *Coverless Creek Bend*

Springfield 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

~~working under my personal supervision.~~

Signed L. P. Seiman

Licensed Embalmer No. 3297

P. O. Address Miller Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.