

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FEB 15 1941
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2495

Registration District No. 347 Primary Registration District No. 3018 Registrar's No.

1. PLACE OF DEATH

(a) County Henry
(b) City or town Clinton
(c) Name of hospital or institution: Community Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hours
In this community 53-9-10 (Specify whether years, months or days)

3. (a) PRINT FULL NAME JESSIE LEE CATON

-3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Schell Caton 6. (c) Age of husband or wife If alive 13-1896 years
7. Birth date of deceased Feb 13-1896 (Month) (Day) (Year)

8. AGE: Years 53 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeping

11. Industry or Business

12. Name William J. Laoh
13. Birthplace Illinois (City, town, or county) (State or foreign country)
14. Maiden name Sarah Bodkins
15. Birthplace Ill (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. R. A. Maguder

(b) Address Appleton City, Mo.

17. (a) Buried (b) Date thereof Jan 25, 1940 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Frank Lee

(b) Address Appleton City, Mo.

19. (a) 1-29-46 (b) D. J. R. Hampton (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Henry
(c) City or town Clinton (If outside city or town limits, write "RURAL")
(d) Street No. 100 (If rural, give location)
(e) If foreign born, how long in U. S. A. 1938 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 year 1940 hour 4:20 minute 5 M.

21. I hereby certify that I attended the deceased from 1938 to 1940; that I last saw him alive on Jan 21, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 8 hrs.

Due to Fall on ice ✓

Due to

Other conditions Hypertension (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence

(c) Where did injury occur? Ohio P. O. McClus, Md. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? On farm (Specify type of place)

While at work yes (e) Means of injury fall

23. Signature Joseph D. Hill (M. D. or other) Address Clinton, Mo. Date signed 1-25-40

186a

RECEIVED
District Health Officer No. 7,
District File Number 2-40-301
Date Filed 2-14-40

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 Me
on the 23rd day of Jan 1940, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. 1099

P. O. Address Appleton City, Wis.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

2495
Do not use this space.

1. PLACE OF DEATH

(a) County Henry

Registration District No. 347

(b) Township Clinton

Primary Registration District No. 3018

Registered No.

(c) City Clinton

(d) Street No.

(If death occurred in Hospital or Institution, write its name instead of street and number) 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

(a) Residence, No. Ohio Postoffice R.R. St. ☐

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

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)

wid

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.
ormin.

53

9

10

OCCUPATION

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.

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)

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME

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

17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19

19. FUNERAL DIRECTOR
(ADDRESS)

20. FILED

Jan 29 1940

Dr. J. R. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1 1940

22. I HEREBY CERTIFY That I attended deceased from

19..... to 19.....

I last saw h..... alive on....., 19..... 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:

Date of onset

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?

If so, specify

(Signed) Joseph B. O'Neill M. D.

(Address) Clinton, Mo.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

2498

Do not use this space.

1. PLACE OF DEATH

(a) County Henry

Registration District No. 347

(b) Township Clinton

Primary Registration District No. 3018

Registered No. _____

(c) City _____

(d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)

(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

(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)

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

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

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4. COLOR OR RACE

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DIVORCED (write the word)

wid

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.

53

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OCCUPATION

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.

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)

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME

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

17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19

19. FUNERAL DIRECTOR
(ADDRESS)

20. FILED

19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1, 1940

22. I HEREBY CERTIFY, That I attended deceased from

19____ to _____, 19____

I last saw h _____ alive on _____, 19____. 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:

Cerebral Hemorrhage Date of onset

Fall on ice 1-1-40

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? accident Date of injury 1-1, 1940

Where did injury occur? home

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall on ice

Nature of injury Cerebral Hemorrhage

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph B. O'Neill M. D.

(Address) Clinton