

Registration District No. 380

Primary Registration District No. 5530

Registrar's No. 5

1. PLACE OF DEATH:
 (a) County Howard
 (b) City or town Rural - Franklin Township
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Middle Highway 40 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community not known
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Arkansas (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME THOMAS CLAYTON 435

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color Black 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. Age: Years Months Days If less than one day hr min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant's own signature

(b) Address

17. (a) removed (b) Date thereof 2-28-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mo University

18. (a) Signature of funeral director CSH American

(b) Address New Franklin Mo

19. (a) 2-28-1940 (b) Clayton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 7 day 11
 year 1940 hour 2:30 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Brain stroke and motor chex
 Due to accident

Due to _____

Other conditions (include pregnancy within 3 months of death) 1940

Major findings: Of operations _____

Of autopsy no

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

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

(b) Date of occurrence 2-11 at 2:30 pm 1940

(c) Where did injury occur? Highway 40 N. Bond Bridge
(City or town) (County) (State)

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

23. Signature J. H. Hawkins

Address Sevier Date signed 2/11/40

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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19412

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RECEIVED
District Health Officer No. 8
District File Number 3-12-40
Date Filed

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..... *C. W. McCann*

Licensed Embalmer No. *3516*

P. O. Address *New Franklin*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6796**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **986**

Primary Registration District No. **5930**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Howard
 (b) City or town Franklin J. O.
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Thomas Clayton
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race Black 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
 7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.
Approximately 35 years

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal) _____
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 18, 1940 (b) Clara V. Landrum
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

19. MEDICAL CERTIFICATION
 20. DATE OF DEATH Month Feb day 11 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw h. _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature W. R. Hawkins (M. D. or other) _____
 Address Bladwin _____ Date signed _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MAY 17 1940

S-6796