

FILED APR 22 1940

Registration District No. 378

Primary Registration District No. 2001

Registrar's No. 217

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hosp.
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community
years, months or days) 1 3 1

3. (a) PRINT FULL NAME Frank Claytor

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased: May 22 1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 21 If less than one day hr. _____ min. _____

9. Birthplace East St. Louis Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Telegrapher

11. Industry or business

MOTHER FATHER { 12. Name John N. Claytor 9
13. Birthplace Unknown (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (State or foreign country)

16. (a) Informant Ples Tolliver
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof March 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 3/3/40 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits write "RURAL")
(d) Street No. Como Hotel
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1
year 1940 hour 1 minute 45 P. M.

21. I hereby certify that I attended the deceased from Feb 25
1940, to March 1, 1940;

that I last saw him alive on March 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 day

Due to Hypertensive cerebral arterio-sclerotic disease

Due to _____

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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) _____

(b) Date of occurrence _____

23. 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? _____

24. While at work? _____ (Specify type of place) _____
(e) Means of injury _____

28. Signature Dr. White (M. D. or other) M.D.

Address Springfield Mo. Date signed 3/2/40

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed L. Doolin Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield 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.

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