

Registration District No. 1041099

Primary Registration District No. 5868

Registrar's No.

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

1. PLACE OF DEATH

(a) County Pemiscot Little River
(b) City or town Pease Beach Ark.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community _____
years, months or days) 435

8. (a) PRINT FULL NAME Carrol Jr. Clayton

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

4. Sex Male 5. Color or race White 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 Dec. 23 - 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 15 _____ hr. _____ min.

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____ 9

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

14. Maiden name Virgia Clayton (City, town, or county) (State or foreign country?)

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

16. (a) Informant Mother Virgia Clayton

(b) Address Pease Beach Ark.

17. (a) Burial (b) Date thereof 3 8 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Burial

18. (a) Signature of funeral director Tambert & Son

(b) Address Campbell Mo.

19. (a) 7-10-70 (b) J.P. Drury
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7
year 1940 hour _____ minute 9 P. M.

21. I hereby certify that I attended the deceased from March 1-1940
to March 7-1940
that I last saw him alive on March 4 and that death occurred on the date and hour stated above.

Immediate cause of death Heart ruptured with dropsy Duration _____

Due to _____

Due to _____

Due to _____

Other conditions (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) _____

(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 J.P. Drury (M. D. or other) _____

Address _____ Date signed _____

4-40-3.

120

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD
BROWENA MAHAR

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 15702

Registration District No. 1099

Primary Registration District No. 3868

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jennison
(b) City or town Little River, T. P.
(If outside city or town limits, write "RURAL" and name of township)
(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 Carroll Jr Clayton

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

4. Sex m 5. Color or race w 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 min.
2 15 _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH _____ Month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis
with dropsy
cause unknown
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 130

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) _____
(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) _____
Means of injury _____
23. Signature B. E. Elly (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

