

FILED JUNE 10 1940

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

18038
Do not use this space.

1. PLACE OF DEATH
 (a) County Callaway Registration District No. 104
 (b) Township 2 Primary Registration District No. 3008 Registered No. 145
 (c) City Auton (d) Street No. _____ St. _____
 (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 Cleda May Clayton
 (a) Residence, No. _____ 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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martin Clayton age 31
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 30, 1914
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
25 7 24
 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. factory worker
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 10 yrs
the factory
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cherokee Iowa
 13. NAME Eugene D. Scott
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cherokee Iowa
 15. MAIDEN NAME Emma Dait
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Auton Mo.
 17. INFORMANT (ADDRESS) Martin M. Clayton Fulton Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Fulton DATE May 26, 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Geo. V. Wallace Fulton, Mo.
 20. FILED May 25, 1940 R. D. Crew Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/24, 1940
 22. I HEREBY CERTIFY, That I attended deceased from 5:10, 1940, to 5:24, 1940
 I last saw her alive on 5/24, 1940 Death is said to have occurred on the date stated above, at 4 p.m.
 The principal cause of death and related causes of importance were as follows:
filariasis
 Date of onset _____
 Other contributory causes of importance:
chr. hypochondriac adynamic ileus 5/18/40
 Name of operation autopsy Date of 5/16/40
 What test confirmed diagnosis? specimen Was there an autopsy? no
 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? no
 If so, specify _____
 (Signed) Henry D. Dues M. D.
 (Address) Fulton, 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.

Social Security No. 493-01-1728

12/1/18

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 *W. H. Simpson*
Licensed Embalmer No. *3965*
P. O. Address *Fulton, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18038

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

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.

3. (a) PRINT FULL NAME

Cleda May Clayton

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

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 25 Months 7 Days 24 If less than one day _____ hr. _____ min.

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

DEATH CERTIFICATION

20. DATE OF DEATH Month 5 day 24 year 1940 hour _____ minute _____ 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 fibroid uterus Duration _____

Organism no found -

Due to non purulent # _____

Due to 134 _____

Other conditions Chr Hydro Salspingitis (Include pregnancy within 3 months of death)

Major findings: Hysterectomy

Of operations _____

Of autopsy H

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 Henry Duret (M. D. or other) _____

Address Fulton Mo Date signed _____

SUPPLEMENTAL COPY

S-18038