

No. 2
-11-10-39
5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24362

State File No.

AUS 14 1940

399

Primary Registration District No. 1002

Registrar's No. 2972

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson City
(c) Name of hospital or institution: 4340 Warwick
(d) Length of stay: In hospital or institution 30 years
In this community 30 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Jackson City
(d) Street No. 4340 Warwick
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1940 hour 5 minute 30 P.M.
21. I hereby certify that I attended the deceased from January 21 to July 20 1940
that I last saw her alive on July 20 1940
and that death occurred on the same date and hour stated above.
Immediate cause of death Coma Uremia

Due to Arterio Sclerosis
Due to _____
Other conditions (include pregnancy within 3 months of death) 97

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work _____
23. Signature [Signature]
Address 1007 Prof. Bldg Date signed 7/24/40

3. (a) PRINT FULL NAME Mrs. Mary May Clayton

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

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

6. (b) Name of husband or wife George N. Clayton 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased July 25 1855
(Month) (Day) (Year)

8. AGE: Years 85 Months 0 Days 0
If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Alvin Woodworth

13. Birthplace No Record
(City, town or county) (State or foreign country)

14. Maiden name _____

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Harvey A. Clayton
(b) Address 4340 Warwick Removal

17. (a) (Burial, cremation, or removal) Removal (b) Date thereof 7-26-40
(Month) (Day) (Year)

(c) Place: burial or cremation Omaha Nebraska
18. (a) Signature of funeral director J. W. Wagner
(b) Address Kansas City, Mo.
19. (a) July 26, 1940 (b) M. M. Erave
(Date received local registrar) (Registrar's signature)

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

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 Cecil R. Matthews

Licensed Embalmer No. 3807

P. O. Address A. C. 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 2972

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(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.....
years, months or days)

3. (a) PRINT FULL NAME Mary May Clayton

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

4. Sex Fe 5. Color or race..... 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
85 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..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) July 26/1940 (b) M. M. Brown (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 July day 25 year 1940 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
Renal anemia
Myocardial infarction
arteriosclerosis
Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death) 131

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) (f) Means of injury.....

23. Signature M. M. Lebermann or other.....

Address 1007 1st St Date signed 8/1/40

Duration

3da

5hrs

10/42

PHYSICIAN

Underline the cause to which death should be charged statistically.

