

FILED SEP 23 1940

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

29032  
Do not use this space.

1. PLACE OF DEATH <sup>2</sup>

(a) County *McDonald* Registration District No. *1117*

(b) Township *Richwood* Primary Registration District No. *5699*

(c) City *Rocky Comfort* (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_

(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 *Charles Roy Clifton*

(a) Residence, No. *Rocky Comfort* St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*

4. COLOR OR RACE *white*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 26-1940*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, *6* hrs. or *6* min.

OCCUPATION

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. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Rocky Comfort Mo.*

FATHER

13. NAME *Harry Clifton*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo. Jane*

MOTHER

15. MAIDEN NAME *Bertha Boler Powell*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

17. INFORMANT (ADDRESS) *Harry Clifton Rocky Comfort Mo. RR*

18. BURIAL, CREMATION, OR REBURIAL PLACE *Fox Cemetery* DATE *7-27-1940*

19. FUNERAL DIRECTOR (ADDRESS) *Wheaton Funeral Home Wheaton Mo.*

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-27-1940*

22. I HEREBY CERTIFY, That I attended deceased from *July 26*, 1940, to *July 27*, 1940

I last saw him alive on *July 27*, 1940. Death is said to have occurred on the date stated above, at *2 P.* m.

The principal cause of death and related causes of importance were as follows:

*Intra Cranial Hemorrhage 7-26-40*

Other contributory causes of importance: *160 P*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? *Clinical* 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? *at birth* (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) *O.S. McCall* \_\_\_\_\_, M. D.

(Address) *Wheaton Mo.*

WRITE PEANUTLY, 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

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RECEIVED

District Health Officer No. 6

District File Number 940-2512

Date Filed SEP 03 1940

STATEMENT BY LICENSED EMBALMER

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
\_\_\_\_\_ L. E. \_\_\_\_\_  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.  
Signed \_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_

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.)

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 29032

Registration District No. 1167

Primary Registration District No. 5699

Registrar's No. 38

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

1. PLACE OF DEATH:

(a) County McDonald

(b) City or town Richwoods  
(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 Charles Roy Clefton

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w

6. (a) Single, widowed, divorced, or married S

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 \_\_\_\_\_

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) Oct. 18-44 (b) Ada Collins  
(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 7 day 27  
year \_\_\_\_\_ 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 \_\_\_\_\_

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)  
Means of injury \_\_\_\_\_

23. Signature D. J. McCall (M. D. or other) \_\_\_\_\_  
Address Wheaton \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

