

State File No. \_\_\_\_\_

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Henry  
 (b) City or town Clinton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
319 W Jefferson  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2  
 In this community 3 yrs  
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry  
 (c) City or town Clinton  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 319 W Jefferson  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8  
 year 1863 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from Oct 7 to Oct 8, 1940  
 that I last saw her alive on Oct 8, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Colon.

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?  
312 (Specify type of place)  
 While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Joseph B. Mill (M. D. or other) \_\_\_\_\_  
 Address Clinton Mo. Date signed 9-10-40

3. (a) PRINT FULL NAME Sarah E. Thomas  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife Benjamin Thomas 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: 12 5 1863  
 (Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Bowling Green Kentucky  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Richard N. Monroel  
 13. Birthplace Kentucky  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Sarah C. Hanes  
 15. Birthplace Virginia  
 (City, town, or county) (State or foreign country)

16. (a) Informant Miss C. H. Gordon  
 (b) Address Clinton Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
 (c) Place: burial or cremation Carpenter Cem.

18. (a) Signature of funeral director Ed. C. Williams  
 (b) Address Clinton Mo.

19. (a) Nov 1-1940 (Date received local registrar) (b) J. B. Mill (Registrar's signature)

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

X21492

3  
7  
2

NOV 19 1940

RECEIVED

District Health Officer No. 7,

District File Number 10-40-1642

Date Filed 11-14-40

**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 Feed Wellman

Licensed Embalmer No. 7478

P. O. Address Clintony Md.

**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. 35433

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Clifton  
(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 Sarah E. Thomas

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

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

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  
76 10 4 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) Dr. J. P. Hamilton  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH 1940 Oct 9 12  
year 12 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 \_\_\_\_\_ Duration \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature Joseph B. O'Neill (M. D. or other) \_\_\_\_\_

Address Clifton, Mo. Date signed \_\_\_\_\_

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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 complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**