14.

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should stat. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 I X19511

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44247

Registration District No. 911 FEB JAN 22 1941

Primary Registration District No. 6228

Registrar's No.

1. PLACE OF DEATH:

(a) County WRIGHT ELK CREEK

(b) City or town HARTVILLE RURAL (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 years, months or days) 85 years

In this community 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County WRIGHT

(c) City or town HARTVILLE Rural (If outside city or town limits, write "RURAL")

(d) Street No. 11 Miles North Hartville (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME SAMUEL ERSKIN CLAXTON

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 MARRIED

6. (b) Name of husband or wife Syntha Claxton

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Aug (Month) 3 (Day) 1855 (Year)

8. AGE: Years 85 Months 4 Days 10 If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business

FATHER
12. Name HENDERSON CLAXTON
13. Birthplace (City, town, or county) TENN (State or foreign country)

MOTHER
14. Maiden name SUSAN HARRISON
15. Birthplace (City, town, or county) TENN (State or foreign country)

16. (a) Informant's own signature Jason Claxton

(b) Address Grove Spring, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 15 40 (Month) (Day) (Year)

(c) Place: burial or cremation DURBIN

18. (a) Signature of funeral director Gene E. Holdren

(b) Address Hartville, Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 13 year 1940 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from Dec first, 1940 to Dec 13, 1940 that I last saw him alive on Dec 13, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Influenza

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. K. Hough (M. D. or other)

Address Grove Spring Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 141-80
Date Filed JAN 10 1941

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 Gene E. Holder

Licensed Embalmer No. 3865

P. O. Address Hartville, 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.

7. S. No. 2B
0M—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44247

Registration District No. 911 Primary Registration District No. 6228 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Wright
(b) City or town Elk Creek
(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 years, months or days)
In this community

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 Samuel Erskin 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 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 85 Months 4 Days 10 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
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) (Date received local registrar) (b) P. H. Smalley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13 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 — Duration
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. V. Hough (M.D. or other)
Address Grove Springs Date signed

SUPPLEMENTARY