

No. 2  
13-  
17-

FILED APR 28 1941  
Registration District No. ....

Primary Registration District No. 210

Registrar's No. 23

1. PLACE OF DEATH: Lewis Hospital  
 (a) County  
 (b) City or town Rural  
 (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  
 In this community years, months or days

2. USUAL RESIDENCE OF DECEASED: 56  
 (a) State  
 (b) County  
 (c) City or town  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 0 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? years.

3. (a) PRINT FULL NAME Martha Elizabeth Clow  
 3. (b) If veteran, name war  
 3. (c) Social Security No.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month March day 6  
 year 1941 hour minute M.

4. Sex Female / 5. Color or race W  
 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife  
 6. (c) Age of husband or wife if alive years  
 7. Birth date of deceased Nov 3 1861  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 10 1940 to March 6 1941  
 that I last saw her alive on March 4 1941  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
 80 4 3 hr. min.

Immediate cause of death  
 Due to Embolic pneumonia & emboli  
 Due to Broken Left Hip  
 Duration 1 1/2 years  
 Dec 10

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER  
 12. Name William Willis Waggoner  
 13. Birthplace Missouri (City, town, or county) (State or foreign country)  
 14. Maiden name Elizabeth Bussell (City, town, or county) (State or foreign country)  
 15. Birthplace Mo (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)  
 Major findings: Of operations 1956  
 Of autopsy 91 19  
 PHYSICIAN Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Ed Fair  
 (b) Address Ewing Mo

17. (a) Burial (b) Date thereof Mar 8 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Old Grises Cemetery

18. (a) Signature of funeral director Thomas Ball  
 (b) Address Ewing Mo  
 19. (a) 3/10/41 (b) P. W. Jennings  
 (Date received local registrar) (Registrar's signature)

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? Means of injury?  
 Signature Harry J. McBracken (M. D. or other)  
 Address Lewis & Main Date signed

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

6  
326

1954  
69

RECEIVED

District Health Officer No. 10

District File Number 4-41-686

Date Filed APR 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 Thomas Ball

Licensed Embalmer No. 1744

P. O. Address Evans, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11220

Registration District No. 477

Primary Registration District No. 200

Registrar's No. 213

1. PLACE OF DEATH

(a) County Lewis  
(b) City or town Highland Twp  
(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 \_\_\_\_\_  
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis  
(c) City or town Rural  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Martha Elizabeth Clow

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 80 Months 4 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) Missouri (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 (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 3/10/41 (b) P.W. Jennings, M.D. (Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 6 year 1941 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 \_\_\_\_\_ 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? \_\_\_\_\_

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

23. Signature Harry L. McClracken (or other) \_\_\_\_\_ Address Leurasoren Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

1941  
S-11220

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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 comply with the above constitutes grounds for revocation of license.)**

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11220

Registration District No. 477

Primary Registration District No. 200

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

1. PLACE OF DEATH:

(a) County Lewis  
(b) City or town Highland Twp  
(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

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

3. (a) PRINT FULL NAME Martha Elizabeth Clow  
3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

Immediate cause of death Euryma p... Duration \_\_\_\_\_

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 80 Months 4 Days 3  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

Due to Senile Dementia  
Due Broken left hip

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

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

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

Of autopsy \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

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

22. If death was due to external causes, fill in the following:

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Nov 8, 1940

(c) Where did injury occur? Highland Twp Lewis Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
in the home

While at work? No (e) Means of injury fall

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

23. Signature Harry M. Brocker (M. D. or other) D.O.  
Address Lewis town, Mo Date signed 6/12/41

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

MOTHER FATHER

SUPPLEMENTARY