

FILED MAY 23 1941

14686

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 13

Registration District No. 14

Primary Registration District No. 421

1. PLACE OF DEATH  
(a) County Henry  
(b) City or town Windsor  
(c) Name of hospital or institution: Windsor Clinic  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

3 (a) PRINT FULL NAME Gene Lowry Clinton  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Child  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 18 1941  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 12 hr. \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 12. Name Armel Clinton  
13. Birthplace Henry County Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Daisy Lowry  
15. Birthplace Johnson County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Armel Clinton  
(b) Address RFD, Leeton, Missouri

17. (a) Burial (b) Date thereof 4-20-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Leeton, Missouri

18. (a) Signature of funeral director Huston-Turner  
(b) Address Windsor Missouri

19. (a) 4-19-41 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Henry  
(c) City or town Windsor  
(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 April day 19 year 1941 hour 10 minute A.M.  
21. I hereby certify that I attended the deceased from April 17, 1941, to April 19, 1941; that I last saw him alive on April 16, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Adolescentis  
Due to Breath Delivery  
Due to Trauma  
Other conditions Fract. Breast  
(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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) Dr.  
Address Windsor, Mo. Date signed 4-19-41

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

**MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH**

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

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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

**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 \_\_\_\_\_

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

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

4. Sex \_\_\_\_\_

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

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) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 \_\_\_\_\_ day \_\_\_\_\_  
 year \_\_\_\_\_ 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 \_\_\_\_\_

**RECEIVED**

Due to **District Health Officer No. 7;**

Due to **District File Number 5-41-895**

**Date Filed 5-31-41**

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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.