

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17605

Registration District No. 207

Primary Registration District No. 5296

Registrar's No. 29-17

1. PLACE OF DEATH:

(a) County Clinton (Consolidated township)  
(b) City or town Rural Plattsburg  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_

In this community 1 mo. 2 weeks (Specify whether years, months or days)

8. (a) PRINT FULL NAME Clyde R Compton

8. (b) If veteran, name war no 8. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased May 23 1924  
(Month) (Day) (Year)

8. AGE: Years 16 Months 11 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Labour

11. Industry or business

12. Name Richard Compton

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

14. Maiden name Elizabeth Ward

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

16. (a) Informant's own signature Richard Compton

(b) Address Stewartville Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 23 41 (Month) (Day) (Year)

(c) Place: burial or cremation Nevada Mo.

18. (a) Signature of funeral director J. Brien-Tyler

(b) Address Plattsburg Mo.

19. (a) May 21-41 (Date received local registrar) (b) Edwice Chastain (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon

(c) City or town Milo (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. B years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20 year 1941 hour 6 minute 40 P.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 Fracture skull right frontal & left occipital regions.  
Due to Contusion brain right frontal  
Contusion and laceration of left occipital lobe.  
Other conditions none  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

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

Of autopsy Findings above

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) Accident

(b) Date of occurrence May 21, 1941

(c) Where did injury occur? Highway, Clinton Mo. (City or town) (County) (State)

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

(Specify type of place) While at work? no (e) Means of injury Auto

23. Signature W. R. Spalding (M.D. or other)

Address Cl. Coroner (Date signed 5-21-41)

Plattsburg Mo

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

FILED JUN 16 1941

1706  
95

**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..... *Danell D. Lyon*.....

Licensed Embalmer No. *3640*.....

P. O. Address..... *Plattsburg Md*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.. (Failure to comply 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. 17605

Registration District No. 207

Primary Registration District No. 5296

Registrar's No.

1. PLACE OF DEATH:

(a) County Clinton  
(b) City or town Concord T.P.  
(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 Clyde R. Compton  
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 S

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

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

8. AGE: Years 16 Months 11 Days 28 If less than one day \_\_\_\_\_ 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 \_\_\_\_\_ (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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21 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) Fractured skull  
frontal and left occipital  
region  
Due to Contusion of Brain at frontal  
Contusion and laceration  
of left occipital lobe

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

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

Of autopsy Fracture skull  
Laceration left occipital lobe

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

(a) Accident, suicide, or homicide (specify) fall from a car with the

(b) Date of occurrence Mar 21 1941 while

(c) Where did injury occur? Stuartsville Hwy Clinton Co

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

While at work? no (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or D. O.) \_\_\_\_\_

Address Platonsky No 15-41

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be assigned separately.

S-17405