No. 2
1-4-4
17-39
X25

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

...IENT OF COMMERCE
...AU OF THE CENSUS
...G 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25626

...District No. 566 — Primary Registration District No. 5762 — Registrar's No. 81

1. PLACE OF DEATH:

(a) County MISSISSIPPI

(b) City or town BERTRAND Mississippi Twp (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 ..... (Specify whether In this community 78 YRS years, months or days)

2. USUAL RESIDENCE OF DECEASED: 67

(a) State MISSOURI (b) County MISSISSIPPI

(c) City or town BERTRAND 0 (If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country NONE 0

3. (a) PRINT FULL NAME AMANDA PAULINA CLAYTON

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex FEMALE 1

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE 0

6. (b) Name of husband or wife NONE

6. (c) Age of husband or wife if alive NONE years

7. Birth date of deceased JUNE (Month) 20TH (Day) 1863 (Year)

8. AGE: Years 78 | Months 0 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace BERTRAND (City, town, or county) MISSOURI (State or foreign country) 0

10. Usual occupation HOUSEKEEPER

11. Industry or business RETIRED

FATHER
12. Name WILLIAM CLAYTON
13. Birthplace McNARY COUNTY (City, town, or county) TENNESSEE (State or foreign country) 1

MOTHER
14. Maiden name MARY BARNES
15. Birthplace McNARY COUNTY (City, town, or county) TENNESSEE (State or foreign country)

16. (a) Informant MRS JOHN GATY

(b) Address BERTRAND, MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-17-41 (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE - CHARLESTON, MO

18. (a) Signature of funeral director LAIR-NUNNELEE

(b) Address CHARLESTON, MO

19. (a) 7-18-41 (Date received local registrar) (b) F D Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 16TH year 1941 hour 12 minute 10 P.M.

21. I hereby certify that I attended the deceased from May 19, 1941 to July 16, 1941, that I last saw her alive on July 17, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

Due to Uremia nephritis, chronic

Due to Fracture with g femur

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 100

(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 G W H Presnell (M. D. ~~or other~~) 1

Address Sikeston Mo Date signed .....

140

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 841-102
Date Filed 8-12-41

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 John F. Nunnelee Jr.

Licensed Embalmer No. 385 T.

P. O. Address Charleston, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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

S. No. 2B
I—8-21-41
29288

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

Silkeston Mo

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25-626

Registration District No. 566 Primary Registration District No. 5762 Registrar's No. 81

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Bertrand
(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 Mo (b) County Mississippi

(c) City or town Bertrand
(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 Amanda P. Clayton

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 S

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 or 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) (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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
year 1941 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
Uremia

Due to nephritis chronic

Due to Fracture of neck of femur

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 186a
Of autopsy 38

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) accident
(b) Date of occurrence June 15-41
(c) Where did injury occur? Silkeston (City or town) Scott (County) Mo (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
Malone Theatre (Specify type of place)
While at work? No (e) Means of injury Fracture

23. Signature G. W. H. Presnell (M. D. or other)
Address Silkeston Mo Date signed 9-20-41