

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED SEP 11 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29493
Registrar's No. 137

Registration District No. 17416

Primary Registration District No. 3038

1. PLACE OF DEATH:

(a) County SALINE
(b) City or town MARSHALL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzcibbers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One day
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT

FULL NAME Jessie Mae Clements

3. (b) If veteran,

name war No

3. (c) Social Security

No. No

4. Sex FEMALE

5. Color or

race White

6. (a) Single, widowed, married,

divorced MARRIED

6. (b) Name of husband or wife

John Clements

6. (c) Age of husband or wife if

alive ? years

7. Birth date of deceased

Aug 26 1894
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>46</u>	<u>11</u>	<u>29</u>	hr. min.

9. Birthplace

Saline Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown
(City, town, or county) (State or foreign country)

14. Maiden name

Unknown

15. Birthplace

Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant

John Clements

(b) Address

MARSHALL Mo

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Aug 27 1941
(Month) (Day) (Year)

(c) Place: burial or cremation

SHARON

18. (a) Signature of funeral director

DON SHORT

(b) Address

MARSHALL Mo

19. (a)

8-27-41
(Date received local registrar)

(b)

Mary Kent
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County SALINE
(c) City or town MARSHALL
(If outside city or town limits, write "RURAL")
(d) Street No. 35 HIGH ST
(If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25
year 1941 hour 9:15 minute A M.

21. I hereby certify that I attended the deceased from May 5
1941 to Aug 25 1941;
that I last saw her alive on Aug 25 1941
and that death occurred on the date and hour stated above.

Immediate cause of death

Uremic Coma

Duration

3 days

Due to

Chronic glomerulonephritis

Due to

Other condition

Hypertensive heart disease

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

Address

(M. D. or other title)

Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4-9-6

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

Donald W. Short

Licensed Embalmer No.

3757

P. O. Address

Miss Hall, Inc.

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.