

FILED OCT 10 1941

STANDARD CERTIFICATE OF DEATH

State File No. 31337

Registration District No. 181

Primary Registration District No. 4701

Registrar's No.

1. PLACE OF DEATH:

- (a) County Christian
 (b) City or town Billings
 (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 12 yrs years, months or days)

3. (a) PRINT FULL NAME

Henry A. Clay

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

3. (c) Social Security No.

4. Sex
- male
5. Color or race
- w.

6. (a) Single, widowed, married, divorced
- 1

6. (b) Name of husband or wife
- Allie Clay

6. (c) Age of husband or wife if

7. Birth date of deceased
- Dec 1 1960
-
- (Month) (Day) (Year)

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

9. Birthplace
- Illinois
- (City, town, or county) (State or foreign country)

10. Usual occupation
- Printer

11. Industry or business

12. Name
- Henry Clay

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

14. Maiden name
- Farene Hewson

15. Birthplace
- New York
- (City, town, or county) (State or foreign country)

16. (a) Informant
- Allie Clay

- (b) Address
- Billings, Mo

17. (a)
- Burial
- (Date thereof
- Sept 27-1941
-)
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation
- Maple Park

18. (a) Signature of funeral director
- T. B. Chaffin

- (b) Address
- Dark, Mo

19. (a)
- Sept 20/41
- (Date received local registrar) (b)
- Mrs. Louise Brown
- (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

- (a) State
- Mo.
- (b) County
- Christian
-
- (c) City or town
- Billings
-
- (If outside city or town limits, write "RURAL")

- (d) Street No.
- no 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
- Sept
- day
- 18
- th
-
- year
- 1941
- hour
- Eleven
- minute
-
- A.M.

21. I hereby certify that I attended the deceased from
- May 15 1940
- to
- Sept 18 1941

- that I last saw
- him
- alive on
- Sept 18 1941
-
- and that death occurred on the date and hour stated above.

- Immediate cause of death
- Coronary occlusion
- Duration
- 1 hour

- Due to
- arteriosclerosis
- unk.

- Due to.....

- Other conditions.....
-
- (Include pregnancy within 3 months of death)

- Major findings:
- 9/4/41
-
- 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?.....

- While at work? (Specify type of place) (e) Means of injury.....

23. Signature
- Charles A. Speare
- (M. D. or other)
- M.D.

- Address
- Billings, Mo
- Date signed
- 9-19

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

RECEIVED

District Health Officer No. 6,

District File Number 1041-1543

Date Filed OCT 6 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..... T. B. Chabbin.....

Licensed Embalmer No. 2192

P. O. Address Clark St

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. 31337

Registration District No. 181

Primary Registration District No. 4107

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Christian
(b) City or town Bellings
(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 Henry A. Clay
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, married
7. Birth date of deceased Dec 1 1860
(Month) (Day) (Year)

8. AGE: Years 80 Months _____ Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept 20 1941 (b) Mrs. Louisa Brown
(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 Sept year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

S-31337