

Registration District No. 1149

Primary Registration District No. 5698

1. PLACE OF DEATH

(a) County Mc Donald
(b) City or town Rural
(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 1
in this community 20 yrs
years, months or days (Specify whether)

3. (a) PRINT FULL NAME EDITH ALLEN CLAYTON

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 7. Color or race 1 6. (a) Single, widowed, married, divorced 9

8. (b) Name of husband or wife RALPH CLAYTON 9. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9 20 1877
(Month) (Day) (Year)

8. AGE: Years 64 Months 17 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation 1st

11. Industry or business _____

MOTHER FATHER { 12. Name Wm Preston Day
13. Birthplace Mojo
(City, town, or county) (State or foreign country)
14. Maiden name LYDIA CASSEY
15. Birthplace MO
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Clayton

(b) Address Mojo

17. (a) Burial (b) Date thereof 10 18 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dopery mo

18. (a) Signature of funeral director L. O. Carnel

(b) Address Pennington mo

19. (a) 10-18-41 (b) L. O. Carnel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Mc Donald
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 3 mi So of Pennington
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 10-day 17
year 1941 hour 12 30 minute a M.

21. I hereby certify that I attended the deceased from 1938 to Oct 17, 1941

that I last saw him alive on Oct 18, 1941

and that death occurred on the date and hour stated above.

Immediate cause of death Tuber Pneumonia Duration 5 days

Due to _____

Due to Paralysis agitans 5 yrs

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 108

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 J. D. Fountain (M. D. or other) J. D.
Address Mojo Date signed Oct 21

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

RECEIVED

District Health Officer No. 67

District File Number 1141-1730

Date Filed NOV 13 1949

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.