

FILED AUG 13 1942

Registration-District No. 1167

Primary Registration District No. 5699

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Mc Donald
(b) City or town Rocky Comfort
(c) Name of hospital or institution: None Richwood Exp
(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 Missouri (b) County Mc Donald
Rocky Comfort
(c) City or town _____ (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.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2nd
year 1942 hour 5 minute P M.

21. I hereby certify that I attended the deceased from June 1 1942, to July 2 1942, that I last saw him alive on June 30 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature O. S. McCall (M. D. or other) _____
Address Wheaton, Mo. Date signed 7-7-42

3. (a) PRINT FULL NAME Charles Oscar Clingenpeel

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

6. (b) Name of husband or wife Sarah Clingenpeel 6. (c) Age of husband or wife If alive _____ years

7. Birth date of deceased March 9 1871
(Month) (Day) (Year)

8. AGE: Years 71 Months 3 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name William Clingenpeel

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

14. Maiden name Emily Mole

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

16. (a) Informant Harold C. Clingenpeel

(b) Address Anderson, Mo. R#2

17. (a) Burial (b) Date thereof July 6 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rocky Comfort, Mo.

18. (a) Signature of funeral director W. H. Morris Cogan

(b) Address Wheaton, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 6,

District File Number 842-1228

Date Filed AUG. 12 1942

1.2.V
-MO

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.....

Wm Morris Pope

Licensed Embalmer No. 3947

P. O. Address Wheaton, Md.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 1167

Primary Registration District No. 5699

Registrar's No. _____

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Rural
(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 _____ (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 _____

3. (a) PRINT FULL NAME

Charles Oscar Clirgenesed

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month _____ Day _____
year 1942 hour _____ minute _____ M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MM (Month) 9 (Day) _____ (Year)

21. I hereby certify that I attended the deceased from _____, 19____; that I have seen him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

8. AGE: Years 71 Months 3 Days 3 (If less than one day _____ min.)

Due to _____
Due to _____

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

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

10. Usual occupation _____
11. Industry or business _____

Major findings:
Of operations _____
Of autopsy _____

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) _____ (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) 8/4/42 (b) L. E. Kirk
(Date received local registrar) (Registrar's signature)

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? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

