

S. No. 1-9.4-41  
5-17-39  
PI X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

37926

State File No. ....

FILED DEC 10 1942

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 62

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2  
1  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH  
(a) County St. Francois  
(b) City or town Bonne Terre  
(c) Name of hospital or institution: Bonne Terre Hospital  
(d) Length of stay: In hospital or institution two weeks  
In this community 85 years  
years, months or days

3. (a) PRINT FULL NAME John Sutherland 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  
6. (b) Name of husband or wife Alva J. Clay  
6. (c) Age of husband or wife if alive 76 years  
7. Birth date of deceased Aug 28 1859  
(Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days 29  
If less than one day ..... hr. .... min.

9. Birthplace Farmington P. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Father

11. Industry or business

MOTHER FATHER  
12. Name Wade H. Clay  
13. Birthplace St. Francois Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Theresa Sutherland  
15. Birthplace St. Francois Co.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. B. Nelson  
(b) Address 640 Oak Kansas City, Mo.

17. (a) Burial (b) Date thereof 11-29-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Masonic

18. (a) Signature of funeral director Cooper Funeral Home  
(b) Address Farmington Mo

19. (a) 11-29-1942 (b) Byrdie B. Buhmeister  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County St. Francois  
(c) City or town Farmington Mo  
(d) Street No. 315 W. Columbia  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 27  
year 1942 hour 7 minute 45A M.

21. I hereby certify that I attended the deceased from Nov 18  
1942, to Nov 27 1942  
that I last saw him alive on Nov 26 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac -  
Valvular Disease

Due to Fractured left hip 13da

Due to .....

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
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? .....  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 094

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

23. Signature Geo. J. Wettkow (M. D. or other) 0  
Address Farmington Mo. Date signed 11-27-42

RECEIVED

District Health Officer No. 3

District File Number 1242

Date Filed 12-8-80

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS

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.....

*me*

Registered Apprentice No.....

working under my personal supervision.

Signed.....

*W. C. ...*

Licensed Embalmer No. 4084

P. O. Address *Summit*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 37926

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 62

**1. PLACE OF DEATH:**

(a) County St. Francois

(b) City or town Bonne Terre  
(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** John Sutherland Clay

**(b) If veteran,** name war \_\_\_\_\_

**(c) Social Security No.** \_\_\_\_\_

**20. DATE OF DEATH:** Month NOV Day 7 Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

**21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.**

**4. Sex** m **5. Color or race** W

**6. (a) Single, widowed, married, divorced.** m

**6. (c) Age of husband or wife if alive** \_\_\_\_\_ years

**7. Birth date of deceased.** Aug 28 1886  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.**

Immediate cause of death Cardiac **Duration** 5 yrs

Due to fractured left hip 13da

Due to Fall - stepping on step to enter his office.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**8. AGE:** Years 83 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

**9. Birthplace** \_\_\_\_\_  
(City, town, or county) (State or foreign country) mo

**10. Usual occupation** \_\_\_\_\_

**Major findings:**

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN** \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**11. Industry or 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 \_\_\_\_\_

**22. If death was due to external causes, fill in the following:**

(a) Accident, suicide, or homicide (specify) Accident?

(b) Date of occurrence Aug 14, 1942

(c) Where did injury occur? Foreman's St. Missouri Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public place - sidewalk

While at work yes (e) Means of injury Fall

**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) \_\_\_\_\_ (b) \_\_\_\_\_**  
(Date received local registrar) (Registrar's signature)

**23. Signature** George Walker (M. D. or other) \_\_\_\_\_  
**Address** \_\_\_\_\_ **Date signed** 1-2-42

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—A PER

MOTHER FATHER

11/14/42

