

ADDD SEP 12 3 1943

Registration District No. \_\_\_\_\_

Primary Registration District No. 3000

Registrar's No. 222

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Festerville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: S.O. Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 hours  
(Specify, whether years, months or days)

In this community 7 hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair

(c) City or town Festerville  
(If outside city or town limits, write "RURAL")

(d) Street No. 1004 S. Orchard  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Hubert Eugene Clive

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11  
year 1943 hour 12 minute 00 A.M.

21. I hereby certify that I attended the deceased from Aug 11 to Aug 11 1943  
that I last saw him alive on Aug 11 1943  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced, single

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

7. Birth date of deceased: Aug 11 1942  
(Month) (Day) (Year)

Immediate cause of death: Pulmonary Atelectasis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 161a

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 6 hr. 40 min.

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_

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

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

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

11. Industry or business \_\_\_\_\_

12. Name Charles Hubert Clive

13. Birthplace Adair Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Magie Marie Clive

15. Birthplace Schuyler Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Magie Clive

(b) Address Kirkville, Mo.

17. (a) Cremation (b) Date thereof 8-11-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation A.S.O. Hosp. Crematory

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) 8/11/43 (b) Mrs. L. Wagner  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address [Address] Date signed 8/11/43

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

RECEIVED

District Health Officer No. 10

District File Number 9-43-1484

Date Filed SEP 10 1943

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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, fact should be so stated above.