

FILED FEB 9 1944

Registration District No. 318

Primary Registration District No. 4461

Registrar's No. 39

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

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Bismarck
(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 _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francois
(c) City or town Bismarck
(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 JESSE PAUL CLINTON

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced SD

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

7. Birth date of deceased Jan. 3 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 14 hr. min.

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

10. Usual occupation 0

11. Industry of business 0

12. Name Jesse H. Clinton

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

14. Maiden name Betha Hunt

15. Birthplace Dor. Run Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Jesse H. Clinton

(b) Address Bismarck Mo.

17. (a) Burial (b) Date thereof July 6-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bismarck

18. (a) Signature of funeral director nom

(b) Address _____

19. (a) Jan. 15-1944 (b) Byrdie Bukhner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5
year 1944 hour 6 minute 20 a M.

21. I hereby certify that I attended the deceased from Jan. 3 1944 to Jan. 5 1944
that I last saw him alive on Jan. 4 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Strangulated Inguinal Hernia
Due to Congenital

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

Major findings: 157g
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) (c) Means of injury _____
Signature H. W. Gale (M. D. or other) _____
Address Bismarck, Mo. Date signed 1-5-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

District Health Officer No. 4
District File Number 244-3301
Date Filed 2-7-44

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.