

FILED FEB 3 1944
Registration District No. **5894**

Primary Registration District No. **4497**

Registrar's No. **6**

1. PLACE OF DEATH:

(a) County **Shelby**
(b) City or town **CLARENCE**
(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 **1**
(Specify whether
In this community **40 yrs.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Shelby**
(c) City or town **CLARENCE**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **WALTER HARVEY CLAWSON**

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 **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **20** years

7. Birth date of deceased **Dec 20 1865**
(Month) (Day) (Year)

8. AGE: Years **78** Months **0** Days **18** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Real Estate**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Andrew Clawson**
13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Hall**
15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ray Clawson**

(b) Address **CLARENCE, MO.**

17. (a) **Burial** (b) Date thereof **1-10-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maplewood - Clarence**

18. (a) Signature of funeral director **E.C. Slapper**

(b) Address **Clarence, Mo.**

19. (a) **Jan. 15 - 1944** (b) **Madge Good**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **8**
year **1944** hour **8:00** minute **A.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Heart attack**
Contributed by acute nephritis

Due to _____

Due to **stroke & coronary injury**

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

Major findings:
Of operations _____
Of autopsy _____

Duration

PHYSICIAN

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 **E.P. Thompson** (M. D. or other) **Coroner**

Address **Shelbyville Mo.** Date signed _____

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

RECEIVED

District Health Officer No. 10

District File Number 2-44-390

Date Filed FEB 8 1944

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..... *Louis C. Zappier*

Licensed Embalmer No. 7261

P. O. Address..... *Claremont, N.J.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Clarence
(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 40yr years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Walter H. Clawson

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 _____

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

7. Birth date of deceased Dec. 20 1905
(Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

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 _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Jan day 8 year 1944 (Feb) minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction Duration _____
Heart attack
Contributed by acute nephritis

Due to _____

Due to Verdict of Coroners jury

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

Major findings: Of operations: _____

Of autopsy: _____

PHYSICIAN _____

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 E.P. Thompson (M. D. or other) _____
Address Shelbyville, Mo Date signed 2-12-44

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

SUPPLEMENTARY

4030