

Registration District No. **6194**

Primary Registration District No. **2015**

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

1. PLACE OF DEATH: **Clinton**
 (a) County **Clinton**
 (b) City or town **Cameron**
 (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)

3. (a) PRINT FULL NAME **Rita Clampitt**
 3. (b) If veteran, name war **NO** 3. (c) Social Security No. **none**

4. Sex **F.** 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 **April 18, 1943**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 --- 9 29 hr. min.

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

10. Usual occupation **Baby**

11. Industry or business _____

MOTHER FATHER {
 12. Name **Alvin Clampitt**
 13. Birthplace **Lyons Kansas,**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Vada Clampitt**
 15. Birthplace **Dekalb Co. Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Alvin R. Clampitt**
 (b) Address **Cameron, Mo.**

17. (a) **Burial** (b) Date thereof **Feb. 19, 1944**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wamsley Ceme.**

18. (a) Signature of funeral director **[Signature]**
 (b) Address **Cameron, Mo.**
 19. (a) **Feb. 19, 1944** (b) **Mrs. Kathleen Harris**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Clinton**
 (c) City or town **Cameron**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **West West 7th.** (If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **17th.**
 year **1944** hour **10** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **4-18-43** to **2-17-44**
 that I last saw her alive on **2-17-44**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Tuberculous meningitis** Duration **10 days**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **14**

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 _____

944 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 **2**

23. Signature **[Signature]** (M. D. or other) **MO**
 Address **Cameron, Mo.** Date signed **2-18-44**

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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.