

FILED MAY 10 1944

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

Primary Registration District No. 5289

Registrar's No. 48

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

1. PLACE OF DEATH:

(a) County CLAY

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

(c) Name of hospital or institution: HOME  
(If not in hospital or institution, write street number or location)

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

In this community LIFETIME  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME GEORGE T. CLARDY

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, MARRIED

6. (b) Name of husband or wife MAMIE FANN CLARDY

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased MAY 15 1871  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	II	3	_____ hr. _____ min.

9. Birthplace CLAY COUNTY MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER- RURAL MAIL CARRIER

11. Industry or business RETIRED 7 YEARS

12. Name GARLAND CLARDY

13. Birthplace PLATTE CO. MO.  
(City, town, or county) (State or foreign country)

14. Maiden name MARGARET VIRGINIA WALLER

15. Birthplace PLATTE CO. MO.  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. GEO. T. CLARDY

(b) Address GASHLAND, MO. R.F.D.

17. (a) BURIAL  
(Burial, cremation, or removal)

(b) Date thereof 4/22/44  
(Month) (Day) (Year)

(c) Place: burial or cremation SMITHVILLE, MO.

18. (a) Signature of funeral director MCCOMAS FUNERAL HOME

(b) Address SMITHVILLE, MO.

19. (a) Apr 24-1944  
(Date received local registrar)

(b) Reed N Henry  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County CLAY

(c) City or town GASHLAND, R.F.D.  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR. day 18  
year 1944 hour 10 minute a. M.

21. I hereby certify that I attended the deceased from August 5 1942 to April 18 1944  
that I last saw him alive on Dec 2 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death: Angina Pectoris

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

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

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 Alfred L Johnson (M.D. or other) D.O.

Address Gashland, Mo Date signed 4/19/44

RECEIVED

District Health Officer No. 8.

District File Number

Date Filed

5-9-44

AUG 16 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 S. A. McCowas

Licensed Embalmer No. 2303

P. O. Address Smithville, Mo.

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.