

FILED NOV 20 1944

Primary Registration District No. **5393**

1. PLACE OF DEATH:

(a) County **Douglas**
(b) City or town **Ava** **Rural** **Benton**
(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) **1**
(d) Length of stay: In hospital or institution **15 days** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **James Edward Clinkingbeard**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **0** 6. (c) Age of husband or wife if alive **10, 1868** years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **75** Months **8** Days **20** If less than one day hr. min.

9. Birthplace **Arno, Missouri** (City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business

12. Name **John David Clinkingbeard**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Hannah Lyons**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **C. V. Clinkingbeard**
(b) Address **Ava, Missouri**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7-2-44** (Month) (Day) (Year)
(c) Place: burial or cremation **Thornfield**

18. (a) Signature of funeral director **Clinkingbeard Funeral Home**
(b) Address **Ava, Missouri**

19. (a) **9-6-1944** (Date received local registrar) (b) **Lula Spaullock** (Deputy Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ozark** **77**
(c) City or town **Pondfork** **0**
(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 **June** day **30** year **1944** hour **2** minute **A.M.**

21. I hereby certify that I attended the deceased from **June 29** 19**44** to **June 29** 19**44** and that death occurred on the date and hour stated above.

Immediate cause of death **malignant bowels** Duration

Due to

Due to

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?

(Specify type of place) (e) Means of injury

23. Signature **L. L. Spaullock** (M. D. or other)
Address **7-5-44** Date signed **7-2-44**

RECEIVED

District Health Officer No. 6,

District File Number

Date Filed

1144-1117

NOV 17 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.....

H. B. Hutchinson

Licensed Embalmer No.....

3431

P. O. Address.....

Osceola 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.