

FILED JAN 13 1945

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

Primary Registration District No. 3038

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

1. PLACE OF DEATH:  
 (a) County Linn  
 (b) City or town Brookfield  
(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 years, months or days)  
 In this community 25 yrs.

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Linn  
 (c) City or town Brookfield  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 412 Macon  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Edward Jackson Clawson  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex M 5. Color of race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Live till Clawson 6. (c) Age of husband or wife if alive 76 years  
 7. Birth date of deceased July 1866  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 12 day 25 year 1944 hour 2 minute A. M.  
 21. I hereby certify that I attended the deceased from July 1944 to 12-25-1944  
 that I last saw him live on 12-23-1944 and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months 5 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace McLean Co. Ill.  
(City, town, or county) (State or foreign country)

Immediate cause of death Myocarditis Chronic 7 mos.  
 Due to Chronic nephritis 2 yrs.  
 Due to \_\_\_\_\_  
 Other conditions enlarged prostate  
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer  
 11. Industry or business \_\_\_\_\_  
 12. Name Wm Clawson  
 13. Birthplace New York  
(City, town, or county) (State or foreign country)  
 14. Maiden name Minnie Myers  
 15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

PHYSICIAN  
 Major findings: Of operations 131 b  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant John Clawson  
 (b) Address Brookfield Mo  
 17. (a) Burial (b) Date thereof Dec 26 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Page Hill Cemetery  
 18. (a) Signature of funeral director Wm Clawson  
 (b) Address Brookfield Mo  
 19. (a) 12-26-1944 (b) W W Coman  
(Date received local registrar) (Registrar's signature)

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)  
 While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
 23. Signature W. B. Simpson (M. D. or other) Doc  
 Address Brookfield, Mo Date signed 12-26-44

**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 Homer Bowden

Licensed Embalmer No. 3295

P. O. Address Brookfield 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.**