

**1. PLACE OF DEATH:** **Nodaway Clearmont**  
 (a) County **Nodaway**  
 (b) City or town **Clearmont**  
 (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 25 years** (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

**3. (a) PRINT FULL NAME Bert Elvin Bears**  
**3. (b) If veteran, name war no** **3. (c) Social Security No.** \_\_\_\_\_

**4. Sex male** **5. Color or race white** **6. (a) Single, widowed, married, divorced widowed**  
**6. (b) Name of husband or wife Ada Elvin Bears** **6. (c) Age of husband or wife if alive 5 years**  
**7. Birth date of deceased January 8, 1879**  
 (Month) (Day) (Year)

**8. AGE:** Years **66** Months **1** Days **16** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

**10. Usual occupation farmer**

**11. Industry or business Wm. Bears**

**12. Name Wm. Bears** **13. Birthplace Ohio**  
 (City or town, or county) (State or foreign country)

**14. Maiden name Elizabeth Lyman** **15. Birthplace Ohio**  
 (City or town, or county) (State or foreign country)

**16. (a) Informant Frank Bears** **(b) Address Clearmont Missouri**

**17. (a) Burial Clearmont Missouri** **(b) Date thereof 3-1-45**  
 (Burial, cremation, or other) (City or town) (County) (State)

**(c) Place: burial or cremation Clearmont Missouri**

**18. (a) Signature of funeral director** **(b) Address Maryville Mo**

**19. (a) Feb 27 1945** **(b) Mrs. W. C. Carpenter**  
 (Date received local registrar) (Registrar's signature)

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

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH: Month February 24**  
**1945** year **Undetermined** hour \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from never**  
**attended** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on **not seen** \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death **apoplexy**  
 Due to **Heart disease**  
 Due to \_\_\_\_\_

Other conditions **none**  
 (Include pregnancy within 3 months of death)  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
 Major findings: **none**  
 Of operations **none**  
 Of autopsy **none** **No Histology**

**22. If death was due to external causes, fill in the following:**  
 (a) Accident, suicide, or homicide (specify) **no indication**  
 (b) Date of occurrence **of either**  
 (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)

**23. Signature L. E. Dean (Coroner)** **(M. D. number) MD**  
**Maryville Mo** Address **Maryville Mo** Date signed **2-27-45**

MOTHER FATHER

Duration  
 Underline the cause to which death should be charged statistically.

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

**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.....

*W L Lee*

Licensed Embalmer No.....

*2539*

P. O. Address.....

*Marquette 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. \_\_\_\_\_

Registration District No. 249

Primary Registration District No. 4270

1. PLACE OF DEATH:  
(a) County Nodaway Clearmont  
(b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Bert A. Bears  
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 W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased: Jan (Month) 1 (Day) 1923 (Year)

8. AGE: Years 66 Months 1 Days \_\_\_\_\_ (less than one day) \_\_\_\_\_ min.

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) MO

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) (Specify whether \_\_\_\_\_)  
(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 Missouri (b) County Nodaway  
(c) City or town Clearmont (If outside city or town limits, write "RURAL")  
(d) Street No. Village (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
not attended by physician  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Probably

Duration \_\_\_\_\_  
Due to unknown  
Due to \_\_\_\_\_  
Other conditions Inguinal Hernia  
(Include pregnancy within 3 months of death) reducible

ADDITIONAL PHYSICIAN \_\_\_\_\_  
Major findings: none  
Of operations: \_\_\_\_\_  
Of autopsy: none  
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) No indications  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? none  
(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)  
(c) Means of injury \_\_\_\_\_

23. Signature L. E. Dean Coroner (M. D. or other) MD  
Address Maryville MO Date signed 3-24-45

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—(MAK) A PERMANENT RECORD

MOTHER FATHER

10292