DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1945

Registration District No. 23-7

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10295

Primary Registration District No. 5854

Registrar's No. 21

1. PLACE OF DEATH:

(a) County: Nodaway

(b) City or town: Hopkins (Rural-Union Twp)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5 miles S.E. Hopkins
(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: 12 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Nodaway 74

(c) City or town: Hopkins (Rural) 0
(If outside city or town limits, write "RURAL")

(d) Street No.: 5 miles S.E. 0
(If rural, give location)

(e) Citizen of foreign country? no 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Myrtle Amanda Clements

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: female

5. Color or race: white

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Otto C. Clements

6. (c) Age of husband or wife if alive: 54 years

7. Birth date of deceased: February 4, 1896 (Month) (Day) (Year)

8. AGE: Years 48 | Months 11 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace: Nodaway County (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: George H. Swaney
13. Birthplace: Nodaway County (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name: Lydia Wilder
15. Birthplace: Nodaway County (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant: Otto C. Clements
(b) Address: Hopkins Missouri.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 2-5-45 (Month) (Day) (Year)
(c) Place: burial or cremation: White Oak cemetery

18. (a) Signature of funeral director: Price Funeral Home
(b) Address: Maryville Mo.

19. (a) Feb 7 1945 (Date received local registrar) (b) Avery Barber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: February day: 2 year: 1945 hour: 6 minute: 50 A.M.

21. I hereby certify that I attended the deceased from 1/1 1945 to 2/2 1945 that I last saw her alive on 1/26 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma of occipito cervical adjacent structures	6 mo
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)
While at work? (e) Means of injury:

23. Signature: C. N. Kirk (M. D. or other) M.D.
Address: Hopkins Mo Date signed: 2/3/45

1949

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 2 1955

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 John W. Price

Licensed Embalmer No. 4281

P. O. Address Maryville Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

B
3
36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 251 Primary Registration District No. 5854 Registrar's No. 21

1. PLACE OF DEATH:

(a) County Nodaway

(b) City or town Rural union Twp.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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

3. (a) PRINT FULL NAME Myrtle A Clements

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. (Month) 4 (Day) 1896 (Year)

8. AGE: Years 48 Months 11 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb day 2
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Carcinoma of Uterus	unknown
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 48 hr

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) MD

Address Date signed

SUPPLEMENTARY

10295