

FILED APR 21 1945

Registration District No. **1000**

Primary Registration District No. **1000**

Registrar's No. **400**

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

1. PLACE OF DEATH

(a) County Buchanan

(b) City or town St Joseph Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital # 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 27 yrs 1 mo 29 days  
(Specify here for years, months or days)

In this community 27 yrs 1 mo 29 days

3. (a) PRINT FULL NAME Thos B Clayton

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex M ( ) race N

5. Color or race N

6. (a) Single, widowed, married, divorced 7, 9

6. (b) Name of husband or wife Not given

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

7. Birth date of deceased Not given 6-9 yrs old  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>—</u>	<u>—</u>	<u>—</u> hr. <u>—</u> min.

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

10. Usual occupation Match repairer

11. MOTHER FATHER

12. Name Not given

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

14. Maiden name Adara Clayton

15. Birthplace Not given  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nancy B Frank

(b) Address 174 2nd St, Portland, Oregon

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

(b) Date thereof 4-17-45  
(Month) (Day) (Year)

(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director Barry Funeral Home

(b) Address 224 20th St, St Joseph, Mo

19. (a) 4-17-45  
(Date received local registrar)

(b) Helen J. Fisher  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

(c) City or town Unionville Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. 11  
(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 8 day 8  
year 1945 hour 2 minute 0 M.

21. I hereby certify that I attended the deceased from Apr 6 to Apr 8, 1945  
that I last saw him alive on Apr 7, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis

Due to Bowel obstruction

Due to ?

Other conditions —  
(Include pregnancy within 3 months of death)

Major findings: 122#

Of operations —

Of autopsy —

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)

(1) Means of injury —

23. Signature Lee J. Shook (M. D. or other)

Address State Hosp # 2 Date signed 4/8/45

Duration —

PHYSICIAN —

Underline the cause to which death should be charged statistically.

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*Was Not Embalmed*

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**