

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17305

FILED JUN 11 1945
Registration District No. 175

Primary Registration District No. 3036

State File No. _____

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Lawrence

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

(c) Name of hospital or institution:
200A Madison
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 11 yr
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

(c) City or town Paris MO
(If outside city or town limits, write "RURAL")

(d) Street No. 200A Madison
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME B. E. L. Clover

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28 year 1945 hour 08 minute 15 P.M.

21. I hereby certify that I attended the deceased from May 10 1945 to May 28 1945
that I last saw her alive on May 27 1945
and that death occurred on the date and hour stated above.

4. Sex fr 5. Color or race W 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife George L. Clover 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 4 1867
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Stomach Duration _____

8. AGE: Years 78 Months 6 Days 19 If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions 460K
(Include pregnancy within 3 months of death)

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

10. Usual occupation Housewife

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Park Clover

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

14. Maiden name unknown

15. Birthplace unknown
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Virginia Rodgers

(b) Address Kirkwood MO

17. (a) Removal (b) Date thereof 5/23/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington MO

18. (a) Signature of funeral director Osceola J. Marsh

(b) Address Paris MO

19. (a) May 23 1945 (b) Eunice Greene
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature W. R. Herson (M. D. or other) _____
Address Across, Mo Date signed May 28

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

MOTHER FATHER

1156

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6;

District File Number 645-636

Date Filed JUN 7 1945

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

Myself

Registered Apprentice No.

working under my personal supervision.

Signed

Oscar L. Marsh

Licensed Embalmer No. 3813

P. O. Address

Lyons 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. June
Registrar's No. 54

Registration District No. 175

Primary Registration District No. 3036

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Musora
(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)

3. (a) PRINT FULL NAME Bell Claver

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 widowed

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

7. Birth date of deceased Nov 4 1944
(Month) (Day) (Year)

8. AGE: Years 78 Months _____ Day _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February Day _____
year 1944 hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
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?
_____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

SUPPLEMENTARY

17305

17305