

**FILED** AUG 9 1945 **STANDARD CERTIFICATE OF DEATH**

Registration District No. 298 Primary Registration District No. 4448 State File No. \_\_\_\_\_ Registrar's No. 12

**1. PLACE OF DEATH:**  
 (a) County Ray Co.  
 (b) City or town Lawsan  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (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** ARTIST CAYLOR  
 (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Clifford Caylor 6. (c) Age of husband or wife if alive 22 years  
 7. Birth date of deceased June 1 1923  
 (Month) (Day) (Year)

8. AGE: Years 20 Months 1 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**  
 12. Name Wm. Fields  
 13. Birthplace Macon Co. Mo. (City, town, or county) (State or foreign country)  
 14. Maiden name Jessie Hayes  
 15. Birthplace Ray Co. Mo. (City, town, & county) (State or foreign country)

16. (a) Informant Mrs. Fern Fields  
 (b) Address Coalgil Mo.

17. (a) Burial (b) Date thereof July 11 '45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawsan

18. (a) Signature of funeral director Jarman Prichard  
 (b) Address Lawsan Mo.

19. (a) July 10-45 (b) Ma Blanch  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Ray 89  
 (c) City or town Lawsan 0  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 0  
 (e) Citizen of foreign country? No 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month July day 9  
 year 1945 hour 8 minute AM.

21. I hereby certify that I attended the deceased from May 1945, to July 9 1945  
 that I last saw her alive on July 9 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Terminal pneumonia  
secondary chestnut lymphatic  
 Due to removal

Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 53  
 Of operations \_\_\_\_\_  
 Of autopsy None

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) (e) Means of injury \_\_\_\_\_  
 23. Signature Arthur Duchon (M. D. or other) \_\_\_\_\_  
 Address Lawsan Date signed July 9, 1945

Duration \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

8-9-45

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 Claude Richard.....

Licensed Embalmer No. 2751.....

P. O. Address Exelsior, Minnesota.....

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.