S. No. 2
M—8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 30 1945

State File No. 38747

Registration District No. 337 | Primary Registration District No. 4497 | Registrar's No. 72

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

1. PLACE OF DEATH:
(a) County: Shelby
(b) City or town: Clarence
(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 years, months or days)
In this community: 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Shelby 102
(c) City or town: Clarence /
(If outside city or town limits, write "RURAL")
(d) Street No.: 0
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country: ____

3. (a) PRINT FULL NAME: Ida May Gwynn
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: Widowed
6. (b) Name of husband or wife: ____
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: April (Month) 25th (Day) 1875 (Year)

8. AGE:

Years	Months	Days	If less than one day
70	5	15	____ hr. ____ min.

9. Birthplace: Marion Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation: House Work
11. Industry or business: ____
12. Name (Father): John Smith
13. Birthplace (Father): (City, town, or country) Mo. (State or foreign country) 0
14. Maiden name (Mother): not known
15. Birthplace (Mother): (City, town, or county) not known (State or foreign country) 0
16. (a) Informant: Mrs Joe Smith
(b) Address: Clarence Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/12/45. (Month) (Day) (Year)
(c) Place: burial or cremation: ### Clarence Mo.
18. (a) Signature of funeral director: Million & Barkelew
(b) Address: Clarence, Mo.
19. (a) Nov 3-45 (Date received local registrar) (b) Ruth Joyner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct. day: 10
year: 1945 hour: 9 a.m. minute: ____ M.
21. I hereby certify that I attended the deceased from Oct. 4, 1945 to Oct. 9, 1945 and that I last saw him alive on Oct. 9, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage
Due to: Hypertension
Due to: ____
Other conditions (Include pregnancy within 3 months of death): ____
Major findings: Of operations: ____
Of autopsy: ____

Duration

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: Frank R. Ray (M. D. or other) M.D.
Address: Clarence, Mo. Date signed: 10-12-45

1547

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 11-45-1730
Date Filed NOV 27 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 ....., Registered Apprentice No. ....., working under my personal supervision.

Signed Henry A Barkelew

Licensed Embalmer No. 3835

P. O. Address Shelbina 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.