S. No. 2
M—5-43
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I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 29 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42375

State File No. 0

Registration District No. 317 Primary Registration District No. 3866 Registrar's No. 2933

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town KIRKWOOD (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 219 Saratoga (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none (Specify whether years, months or days)
In this community 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST. LOUIS 96
(c) City or town KIRKWOOD (If outside city or town limits, write "RURAL") 4
(d) Street No. 219 Saratoga (If rural, give location) 3
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ARTHUR CLAYTON
3. (b) If veteran, name war WORLD WAR I
3. (c) Social Security No. NONE
4. Sex MALE 2
5. Color or race COL.
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife UNKNOWN
6. (c) Age of husband or wife if alive UNKNOWN years
7. Birth date of deceased MAR. (Month) 12, (Day) 1893 (Year)

8. AGE: Years	Months	Days	If less than one day
52	9	11	hr. min.

9. Birthplace LOTTIE DALE (City, town, or county) MISS. (State or foreign country) 1
10. Usual occupation MINISTER
11. Industry or business
FATHER 12. Name SAM CLAYTON
13. Birthplace LOTTIE DALE (City, town, or county) MISS. (State or foreign country) 1
MOTHER 14. Maiden name UNKNOWN
15. Birthplace LOTTIE DALE (City, town, or county) MISS. (State or foreign country) 1
16. (a) Informant MAMIE WILSON
(b) Address 219 Saratoga
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation MERIDIAN, MISS.
18. (a) Signature of funeral director ALLEN DAILES
(b) Address 3506 FRANKLIN AVE
19. (a) 12-28-45 (Date received local registrar) (b) E. McDaniel M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 24 year 1945 hour 3 minute P.M.
21. I hereby certify that I attended the deceased from Death without medical attendance. to ....., 19.....; that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death UNKNOWN (History of empyema and sudden death) — Duration
Due to 7100
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy No autopsy

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 0
23. Signature Marvin Freed M.D. (M. D. or other)
Address 601 Brentwood Blvd. Date signed 12/26/45

(Licensed Embalmer's Statement on Reverse Side)

JAN 14 1946

JAN 16 1946

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 James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 3704 Finney

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.