S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42688

FILED JAN 5 1946

Registration District No. 3 6 Primary Registration District No. 6206 Registrar's No. 5

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Oscar - (Rural) (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 no (Specify whether years, months or days) In this community Twelve years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Texas 107
(c) City or town Rural (If outside city or town limits, write "RURAL") 0
(d) Street No. 0 (If rural, give location) 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas Smith CLAYTON
3. (b) If veteran, name war World War 1
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 10, 1895 (Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 4 If less than one day hr. min.

9. Birthplace Clear Springs (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Postmaster
11. Industry or business
FATHER
12. Name Henry H. Clayton
13. Birthplace ~~Clear Springs~~ West Frankfort (City, town, or county) Illinois (State or foreign country)
MOTHER
14. Maiden name Serena Morris
15. Birthplace Rolla (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Nell Clayton
(b) Address Licking, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17th (Month) (Day) (Year)
(c) Place: burial or cremation Boone Creek
18. (a) Signature of funeral director Smith - Ferguson
(b) Address Licking, Mo.
19. (a) Nov. 5, 1945 (Date received local registrar) (b) Myrtle Craig (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14th. year 1945 hour 9 minute A.M.
21. I hereby certify that I attended the deceased from Oct 14-45, 19..., to Oct 14, 1945 that I last saw him alive on Oct 14, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Circulatory Failure	15 min.
Due to Sub-Acute Myocarditis	6 mo.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations / Of 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
23. Signature Harry E. Williams M.D. (M.D. or other)
Address Licking Date signed Oct 15-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No 5
District File Number 1246.452
Date Filed 12-29-46

JAN 14 1946

APR 9 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 E E Ferguson

Licensed Embalmer No. 3945

P. O. Address Pickering Ohio

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.