

FILED FEB 5 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Cole
 (b) City or town Jefferson City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 718 Broadway
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 80 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26
 (c) City or town Jefferson City 5
 (If outside city or town limits, write "RURAL")
 (d) Street No. 718 Broadway
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME William Johnson Clinkenbeard

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Margaret 6. (c) Age of husband or wife if alive 76 years
 7. Birth date of deceased March 10 1856
 (Month) (Day) (Year)

8. AGE: Years 89 Months 10 Days 9 If less than one day _____
 by _____ min.

9. Birthplace Red Rock Iowa
 (City, town, or county) (State or foreign country)

10. Usual occupation Dayman

11. Industry or business _____

12. Name Wm Clinkenbeard

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

14. Maiden name Claude Montgomery

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

16. (a) Informant Alex Clinkenbeard

(b) Address 304 Union

17. (a) Burial (b) Date thereof Jan 21 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of funeral director James
 (b) Address 202 Jefferson
 19. (a) 1-21-46 (b) J. R. G. Barrow, MD
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19
 year 1946 hour 7 minute 30 M.

21. I hereby certify that I attended the deceased from Nov 15
 1945 to Jan 19 1946

that I last saw him alive on Jan 10 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

uremia

Due to senility 3446

Due to repeated

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

Major findings: Of operations _____

Of autopsy no

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 injury) (c) Means of injury _____

23. Signature E. W. Marney (M. D. or other) _____

Address Jefferson City, Mo Date signed 1-21-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 2-4-46

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 *J. A. Hudson*

Licensed Embalmer No. 3641

P. O. Address *Jeno*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. *Feb*

Registration District No. *77*

Primary Registration District No. *3016*

Registrar's No. *15-*

1. PLACE OF DEATH:

(a) County *Jefferson*
(b) City or town *Jefferson city*
(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 *William J. Clirkenhead*

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

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

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

7. Birth date of deceased *man* (Month) (Day) (Year)

8. AGE: Years *89* Months *6* Days _____ If less than one day _____ hr. _____ min.

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

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 _____ Day _____ Year *1946* 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 *chronic nephritis*

Due to _____

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

Major findings: Of operations _____

Of autopsy *BI* _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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