

FILED MAY 8 1946 **STANDARD CERTIFICATE OF DEATH**

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 438

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 24 hrs. 8 mo. 29 da.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 216 Theodore Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME WILLIAM CLAY

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 7
year 1946 hour 5 minute 50 A.M.

4. Sex Male 5. Color or race Negro

6. (a) Single, widowed, married, divorced 9 9

6. (b) Name of husband or wife (unknown)

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 5-9-1887
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3-1-1943 to 4-6-1946
that I last saw him alive on 4-6-1946
and that death occurred on the date and hour stated above.

Immediate cause of death Mycocarditis

8. AGE: Years Months Days If less than one day

58 10 28 hr. min.

Due to Syphilis

Due to

9. Birthplace Gower Missouri
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) 300

10. Usual occupation Laborer

Major findings: Of operations

11. Industry or business Common Labor

Of autopsy Mycocarditis Syphilis

12. Name Joe Clay

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

14. Maiden name Augie ?

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

16. (a) Informant Welfare Board

(b) Address St. Joseph, Missouri

17. (a) Confession (b) Date thereof 4 9 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hospital

18. (a) Signature of funeral director

(b) Address 1602 Main

19. (a) Apr. 18, 1946 (b)
(Date received local registrar) (Registrar's signature)

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 J. H. Moreson (M. D. or other)
Address State Hospital No. 2 Date signed 4-7-46

Duration unknown

Duration unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed.....

4081

Licensed Embalmer No.

P.O. Address.....

4081

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.