DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 7 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23335

Registration District No. 123 Primary Registration District No. 5458 Registrar's No. 53

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Rural - Walnut Grove Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Walnut Grove, Mo. R#1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 71 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 34
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Walnut Grove Mo. R#1
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME WILLIAM LEANDER CLAYPOOL

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 MARY JANE CLAYPOOL
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased NOVEMBER (Month) 29 (Day) 1871 (Year)

8. AGE: Years 74 Months 7 Days 19 If less than one day ..... hr. ..... min.

9. Birthplace POLK Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation FARMER
11. Industry or business FARM
FATHER
12. Name GEORGE CLAYPOOL
13. Birthplace — (City, town, or county) KY. (State or foreign country)
MOTHER
14. Maiden name MARY E. HARPER
15. Birthplace — (City, town, or county) KY. (State or foreign country)
16. (a) Informant William Leonard Claypool
(b) Address Greenfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Turkey Creek Cemetery
18. (a) Signature of funeral director Gene A. Brum
(b) Address Walnut Grove, Mo.
19. (a) 7/19/1946 (Date received local registrar) (b) Nelson L. Murray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18 year 1946 hour 8 minute 00 P.M.
21. I hereby certify that I attended the deceased from on July 18 1946 to ..... 19..., that I last saw him alive on July 18 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Malignant Prostate

Due to Also Arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 J. H. Sarbo MD (M. D. or other)
Address Walnut Grove Mo Date July 19-46

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
Greene County Health Office,
County File Number 46-8-96
Date Filed 8-5-46

SEP 25 1957

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 Warren D. Noblitt
Licensed Embalmer No. 4005
P. O. Address Ash Grove,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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STANDARD CERTIFICATE OF DEATH

State File No. Aug

ration District No. 123 Primary Registration District No. 5458 Registrar's No. 53

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

LACE OF DEATH:

County Greene

(b) City or town 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 (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME William L. Claypool

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 years

7. Birth date of deceased Nov. (Month) 29 (Day) 87 (Year)

8. AGE: Years 74 Months 7 Days 19 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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 July 28
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 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 Cancer of Prostate

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 51b

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 [illegible] (M.D. or other)
Address Walnut Grove, Mo Date signed 8-28-46

SUPPLEMENTARY

22191

23335