

FILED OCT 27 1946
 Registration District No. **42**

Primary Registration District No. **1000**

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:
Missouri Methodist Hospt.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 2 days**
 (Specify whether
 In this community **3 days**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Kansas** (b) County **Brown**
 (c) City or town **Washington Willis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Clyde LeRoy Hutton**
 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 **Single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Aug 11, 1946**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 14 hr. min.

9. Birthplace **Willis, Kansas**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Child**

11. Industry or business _____

MOTHER FATHER
 12. Name **Glenn Earl Hutton**
 13. Birthplace **Gas City, Kansas**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Sybil Mantley Nash**
 15. Birthplace **Evanston Ill.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **C. L. Shifflett**
 (b) Address **Effingham, Kansas**

17. (a) **Removal** (b) Date thereof **9/26/46**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Effingham, Kansas**

18. (a) Signature of funeral director **Clark Manning**
5025 King Hill Ave.
 (b) Address

19. (a) **Oct. 1, 1946** (b) **AJ Westhuck**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **25** year **1946** hour **10** minute **30 P.** M.
 21. I hereby certify that I attended the deceased from **Sept 23** 19**46** to **Sept 25** 19**46**
 that I last saw him **live** on **Sept 25** 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Prematurity
Congenital Heart
Disease
 Duration **45 da**
45 da

Due to _____
 Due to _____
 Other conditions **Bilateral Congenital Inguinal Hernias**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations **none**
 Of autopsy **none**
 PHYSICIAN **JE**
 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?

While at work? _____ (Specify type of place)
 23. Signature **W Ross Moore** (M. D.)
 Address **St Joseph Mo** Date signed **9/27/46**

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

28430

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Eric Clark

Licensed Embalmer No. *4238*

P. O. Address. *St. Joseph, Mo.*

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.