

S. No. 2
M-8-43
7-5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18262

State File No. _____

FILED **MAY 19 1947**

Registration District No. 250

Primary Registration District No. 4376

Registrar's No. 10

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

1. PLACE OF DEATH:

(a) County Madawson

(b) City or town Gulfport
(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 60 years
years, months or days

3. (a) PRINT FULL NAME CLARENCE M. BRITTA

3. (b) If veteran, name war No

3. (c) Social Security No. 487-10-5579

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Anna Britta

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased July 25 1879
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Clarence Britta

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

14. Maiden name Anna Britta

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

16. (a) Informant Mrs. Anna Britta

(b) Address Gulfport

17. (a) Buried (b) Date thereof 5/4-47
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Gulfport

18. (a) Signature of funeral director W. R. Jackson

(b) Address Marionville, Mo

19. (a) May 6 1947 (b) Mrs. E. J. Crenshaw
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madawson

(c) City or town Gulfport
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1947 hour 0 minute _____ M.

21. I hereby certify that I attended the deceased from March 14, 1947 to May 1, 1947
that I last saw him alive on April 25, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 6 weeks

Due to Generalized Arteriosclerosis
of Rare - Apparently
healed. treated at
Columbus Mo. Returned home

Other conditions healed

(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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. R. Jackson (M. D. or other) _____

Address Marionville, Mo Date signed 5-3-47

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 G. M. Atchison

Licensed Embalmer No. 2279

P. O. Address Marionville

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.