

S. No. 2
DM-8-43
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21725**
Registrar's No. **64**

Registration District No. **237**

Primary Registration District No. **4353**

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

1. PLACE OF DEATH:
 (a) County New Madrid
 (b) City or town Hidden, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: no
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no
(Specify whether
 In this community 20 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County New Madrid
 (c) City or town Hidden
(If outside city or town limits, write "RURAL")
 (d) Street No. 8
(If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME OLLIE ISABELLE McCLENDON.
 3. (b) If veteran, name war no. 3. (c) Social Security No. no

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 25
 year 1947 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
 that I last saw him alive on _____ 19____
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced, widowed
 (b) Name of husband or wife William M. Clendon 6. (c) Age of husband or wife if alive 67 years
 7. Birth date of deceased: July 1 1885
(Month) (Day) (Year)

Immediate cause of death Myocarditis
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) None

8. AGE: Years 61 Months 10 Days 5
 If less than one day _____ hr. _____ min.

Major findings:
 Of operations _____
 Of autopsy NO

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

10. Usual occupation Housewife

11. Industry or business no.

12. Name Lawsen Bess
 13. Birthplace unknown, Illinois
(City, town, or county) (State or foreign country)

14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M. Clendon
 (b) Address Bartholomew, Mo.

17. (a) Burial (b) Date thereof 4-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Stephens

18. (a) Signature of funeral director W. H. Bess
 (b) Address St. Stephens, Mo.

19. (a) June 29, 1947 (b) Mrs. Byron Sharp
(Date received local registrar) (Registrar's signature)

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? _____

23. Signature W. H. Bess (Specify type of place) _____ (e) Means of injury Car
 Address New Madrid Mo Date signed 4/28/47

RECEIVED

District Health Office No. 2,

District File Number 747-255

Date Filed 2-9-47

*Milner
710 Easton
Carrollville, 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.....

Licensed Embalmer No.....

P. O. Address.....

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.