

FILED AUG 26 1947

Registration District No. 53 Primary Registration District No. 3010 State File No. \_\_\_\_\_ Registrar's No. 251

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

**1. PLACE OF DEATH:**  
 (a) County Cape Girardeau  
 (b) City or town Cape Girardeau  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Francis Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days.  
 In this community 2 days  
 years, months or days (Specify whether)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County New Madrid  
 (c) City or town Rural Lewis Twsp.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2 miles west of Lilbourn.  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Ernst Clinkscale  
 (b) If veteran, name war No.  
 (c) Social Security No. 432-34-2466

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month August day 15  
 year 1947 hour 6 minute P. M.

4. Sex Male 5. Color or race Colored  
 6. (a) Single, widowed, married, divorced Married  
 (b) Name of husband or wife Fay Clinkscale  
 (c) Age of husband or wife if alive 34 years  
 7. Birth date of deceased: August 19 1909  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from August 12 1947 to Aug 15 1947  
 that I last saw him alive on Aug - 15 - 1947  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death: Colitic ulceration 2 1/2 months  
 Duration: \_\_\_\_\_

**8. AGE:**  
 Years 37 Months 11 Days 26  
 If less than one day hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Center Ridge, Arkansas.  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer.

11. Industry or business \_\_\_\_\_

12. Name Ira Clinkscale.  
 13. Birthplace Tennessee.  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant William McKinney  
 (b) Address Lilbourn, Missouri.

17. (a) Burial (b) Date thereof: 8-20-47  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul-Wardell, Mo.

18. (a) Signature of funeral director Ponder Funeral Home  
 (b) Address Lilbourn, Missouri.

19. (a) 8-20-1947 (b) C. C. Summers  
 (Date received local registrar) (Registrar's signature)

Major findings:  
 Of operations 120A  
 Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) no  
 (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. W. Waxley (M. D. or other)  
 Address Cape Girardeau Date signed 8-4-47

RECEIVED

District Health Officer No. 4

District File Number 847-109

Date Filed 8-25-47

AUG 29 1947

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 Walter L. Ponder

Licensed Embalmer No. 3367

P. O. Address Lilbourn, 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.