No. 2
A-2143
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 4 1948

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3816

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 61

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C.O.S. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution on admission (Specify whether
In this community 10 minutes
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County 998

(c) City or town Clear Lake 13
(If outside city or town limits, write "RURAL")

(d) Street No. 612 W. Division 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME George Franklin Clough
FRANKLIN CLOUGH

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex M 0 5. Color or race W 6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased December 11, 11 1943
(Month) (Day) (Year)

8. AGE: Years 4 Months 2 Days 15 If less than one day hr. min.

9. Birthplace Kirksville (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name G. Herbert Clough
13. Birthplace Cleveland (City, town, or county) Ohio 1 (State or foreign country)

MOTHER
14. Maiden name Valeria Williamson
15. Birthplace Tulsa (City, town, or county) Oklahoma 1 (State or foreign country)

16. (a) Informant Dr. G. Herbert Clough
(b) Address Clear Lake, Iowa

17. (a) Clear Lake, Ia. (Burial, cremation, or removal) (b) Date thereof 2-29-48 (Month) (Day) (Year)
(c) Place: burial or cremation Clear Lake, Iowa

18. (a) Signature of funeral director Davis Funeral Home
(b) Address Kirksville, Missouri

19. (a) 2-27-48 (Date received local registrar) (b) Nate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 26
year 1948 hour 11 minute 40 A.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

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Generalized Peritonitis Suppurative

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 3

23. Signature Foster R. Easley (M. D. or other) Corona

Address Brashear Mo Date signed 2-27-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number 3-48-
Date Filed MAR 2 1948

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 Clarence M. Bills

Licensed Embalmer No. 4375

P. O. Address Kirksville

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

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

No. 2B
3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3816

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 61

1. PLACE OF DEATH

(a) County Adair

(b) City or town Kirksville
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME George F. Clough

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased See (Month) (Day) (Year)

8. AGE: Years X Months 2 Days 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Feb. Day 26 year 1948 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 — Duration

Due to

Due to Pneumococci found in abdominal fluid

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Generalized pneumococcal peritonitis

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 Foster R. Eadey Coroner (M.D. or other)

Address Date signed

SUPPLEMENTARY

1948
S-3816