

No. 300  
10-47  
5-17-39  
I 3906

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28831  
Registrar's No. 57

FILED OCT 11 1948

Registration District No. 15

Primary Registration District No. 5072

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

1. PLACE OF DEATH:

(a) County Barton  
(b) City or town Rural Newport Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: At Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 7 months 8 days years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri; (b) County Barton  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3 miles south Milford, Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT Margretta Jean Clawson  
FULL NAME

3. (b) If veteran, name war No 3. (c) Social Security No. None

20. DATE OF DEATH: Month October day 1  
year 1948 hour 6:15 minute P.M.

21. I hereby certify that I attended the deceased from April  
the first 1948, to October 1 1948  
that I last saw h. aw alive on Sept. 15 1948  
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 \_\_\_\_\_

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

7. Birth date of deceased February 23 1948  
(Month) (Day) (Year)

8. AGE: Years 0 Months 7 Days 8  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation None

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

12. Name James Loren Clawson

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

14. Maiden name Selma Jean Wilkins

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

16. (a) Informant Mr. James L. Clawson

(b) Address Milford, Mo.

17. (a) Burial (b) Date thereof Oct. 3, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newport Cemetery

18. (a) Signature of funeral director Chiles Funeral Home

(b) Address Lamar, Mo.

19. (a) OCT 2 - 1948 (b) Marie Konantz  
(Date received local registrar) (Registrar's Signature)

Immediate cause of death \_\_\_\_\_  
Congenital hydrocephalus  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 8 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
570  
12

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 DR. Guldner (M. D. or other) \_\_\_\_\_  
Address LANE Date signed Oct 2

Duration 7 weeks  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 1048-1158

Date Filed 10-9-48

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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 W. Gule

Licensed Embalmer No. 3473

P. O. Address Same 1960

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.