

FILED MAY 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15507

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 414

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hartville (Rural)</u>	
c. LENGTH OF STAY (in this place) <u>4 Days</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>O'Reilly VA Hospital</u>		e. ADDRESS <u>0</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Homer</u> b. (Middle) <u>O.</u> c. (Last) <u>CLAXTON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 7, 1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 12, 1893</u>
9. AGE (In years last birthday) <u>55</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>26</u>	IF UNDER 2 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	11. BIRTHPLACE (State or foreign country) <u>Hartville, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>John H. Claxton</u>	
13b. MOTHER'S MAIDEN NAME <u>Leora Hamilton</u>		14. NAME OF HUSBAND OR WIFE <u>---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clinical Records O'Reilly VA Hospital</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease with myocardial Damage.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>420</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 3, 1949</u> to <u>May 7, 1949</u> , that I last saw the deceased alive on <u>May 7, 1949</u> , and that death occurred at <u>4:05 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE OF PHYSICIAN (Degree or title) <u>PAUL L. EISELE, M. D.</u>		23b. ADDRESS <u>O'Reilly VAH, Springfield, Mo</u>	23c. DATE SIGNED <u>5-7-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5-10-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cold Water</u>	24d. LOCATION (City, town, or county) (State) <u>Wright County</u>
DATE REC'D BY LOCAL REG. <u>5-13-49</u>	REGISTRAR'S SIGNATURE <u>W. Z. Handley M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gene E. Holden Norwood, Mo.</u>	

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

NOV 28 1949

STPL 32 NDA

JAN 23 1951

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, *of* _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Thomas J. Halliday*

Licensed Embalmer No. *4317*

P. O. Address *Nowood, 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.