

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26524

State File No. _____

FILED AUG 31 1949

Registrar's No. 37

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 4170

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>DeKalb</u>	
b. CITY OR TOWN <u>Union Star Mo.</u>	c. LENGTH OF STAY (In this place) <u>10 yrs</u>	c. CITY OR TOWN <u>Union Star</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ALBERT</u>	b. (Middle) <u>CLEVELAND</u>	c. (Last) <u>CLANCY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 1 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>Sept 24 1884</u>	9. AGE (In years) (Months) (Days) (Hours) (Min.) <u>65</u>	10. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Alpheus P. Clancy</u>	13b. MOTHER'S MARDEN NAME <u>Sarah C. Dickson</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Earl Clancy</u>	ADDRESS <u>Union Star Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>4/20/1</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug 1, 1949, to Aug 1, 1949, that I last saw the deceased alive on Aug 1, 1949, and that death occurred at 2 P. m., from the causes and on the date stated above.

23a. SIGNATURE* <u>E M Reynolds M.D.</u> (Degree or title)	23b. ADDRESS <u>Union Star Mo</u>	23c. DATE SIGNED <u>Aug 3-49</u>
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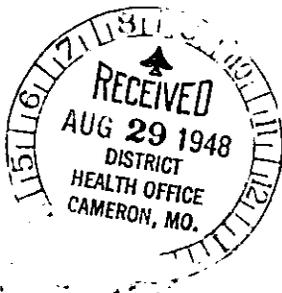
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 3 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Union Star</u>	24d. LOCATION (City, town, or county) (State) <u>1/2 mile north of Union Star Mo</u>
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DATE REC'D BY LOCAL REG. <u>Aug 2 1949</u>	REGISTRAR'S SIGNATURE <u>Reverend [Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Linda M. Wilson</u>	ADDRESS <u>King City Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

31000



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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Lucile M. Wilson

Signed _____
Student Embalmer

Licensed Embalmer No. 2830

P. O. Address King City, 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.