

BIRTH NO. _____ REG. DIST. NO. 240 PRIMARY REG. DIST. NO. 4357 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Marston</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Marston Mo</u> <u>0720</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>Marston, Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>			

3. NAME OF DECEASED a. (First) <u>Permelia</u> b. (Middle) <u>Clayton</u> c. (Last) <u>Clayton</u>			4. DATE OF DEATH (Month) <u>April</u> (Day) <u>12</u> (Year) <u>1950</u>		
(Type or Print)					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 6, 1871</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) <u>Webster County Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mr. E. L. Clayton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. E. L. Clayton</u> ADDRESS <u>Marston, Mo.</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> <u>Previous cerebral Hem.</u> DUE TO (c) <u>Chronic Nephritis</u>		<u>7</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>8 weeks</u> <u>7</u> <u>231X</u>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 Feb. 3, 1950, to April 12, 1950, that I last saw the deceased alive on April 8, 1950, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>John J. Killian MD</u>		(Degree or title)		23b. ADDRESS <u>Portageville, Mo</u>		23c. DATE SIGNED <u>4-18-'50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 13, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Matthews, Missouri</u>		24d. LOCATION (City, town, or county) (State) <u>Matthews, New Madrid, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>April 22 1950</u>		REGISTRAR'S SIGNATURE <u>H. L. Bondar</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Deputy</u>		ADDRESS <u>Wagner Funeral Home, Portageville, Mo</u>	

RECEIVED APR 31
District Health Office
District File Number 450
Date Filed _____

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.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4695

P. O. Address _____

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.