

FILED AUG 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26720

State File No.

BIRTH NO. _____ REG. DIST. NO. 143 PRIMARY REG. DIST. NO. 5558 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Howell</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>"R" DRY CREEK TWP.</u>		c. LENGTH OF STAY (in this place) <u>66 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>"R" DRY CREEK TWP.</u>		0460		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Res.</u>				d. STREET ADDRESS (If rural, give location) <u>POMONA, MO., ROUTE 2</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>CLARENCE</u> b. (Middle) <u>WILSON</u> c. (Last) <u>WASHBURN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 9, 1950</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>JULY 5, 1879</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	IF UNDER 60 MINS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>RICH HILL, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>SARAH BELLE WASHBURN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Sarah Washburn, Pomona, Mo. Rt. 2</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma on Neck (Posterior)</u>					INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchial Asthma</u>					<u>1991</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <u>14 Nov</u> , 19 <u>49</u> , to <u>9 Aug</u> , 19 <u>50</u> , that I last saw the deceased <u>on 15 Jan, 1950</u> , and that death occurred at <u>9:15 P. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Robert M. D. O.</u>				23b. ADDRESS <u>West Plains, Mo.</u>		23c. DATE SIGNED <u>AUG 11 1950</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG. 12, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>Howell Co., Dry Crk. Twp., Mo.</u>		
DATE REC'D BY LOCAL REG. <u>9-3-50</u>		REGISTRAR'S SIGNATURE <u>Northlee Ballard</u> 387		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hal Shoultz, W. Plains, Mo.</u>				

*S (Licensed Embalmer's Statement on Reverse Side)

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

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED AUG 21 1950

Dist. File 85-0-1010

Date Filed 8-22-50

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, as by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Hal Stoubergh

Licensed Embalmer No. 3408

P. O. Address W. Plains, 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.