

FILED FEB 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7218

BIRTH NO. _____ REG. DIST. NO. 328 PRIMARY REG. DIST. NO. 6112 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CHAFFEE		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION RED #1		d. STREET ADDRESS (If rural, give location) RED #1	
3. NAME OF DECEASED (Type or Print) CLAYTON CLIFTON LITTLEPAGE			4. DATE OF DEATH (Month) (Day) (Year) FEB 4 1951
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH FEB 11 1888
9. AGE (In years if under 1 year last birthday) Months Days Hours Min. 6 2 11 23		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMISCO B.R.	
10b. KIND OF BUSINESS OR INDUSTRY PAINTER		11. BIRTHPLACE (State or foreign country) NO RECORD ILL.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME THEODORE LITTLEPAGE	
13b. MOTHER'S MAIDEN NAME NANNY HOWARD		14. NAME OF HUSBAND OR WIFE MARCELLA LITTLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. JULY 28-1918 499-03-80	
17. INFORMANT'S SIGNATURE OR NAME Marcella Littlepage		ADDRESS CHAFFEE	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis	
ANTECEDENT CAUSES		DUE TO (b) _____	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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"/>		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) (Minute)		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 4 1951 to Feb 4 1951, that I last saw the deceased alive on Feb 4, 1951, and that death occurred at 4:55 p.m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) W. Samples M.D. Chaffee Mo		23b. ADDRESS	
23c. DATE SIGNED 2-9-51		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 2-7-51		24c. NAME OF CEMETERY OR CREMATORY DENNIS CEM.	
24d. LOCATION (City, town, or county) (State). ORAN MO-SCOTT		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Fred Bisping	
25. ADDRESS 443		26. DATE REC'D BY LOCAL REG. Feb 8-1951	

(Licensed Embroider's Statement on Reverse Side)

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

1000

RECEIVED FEB 12 1951
SCOTT COUNTY HEALTH CENTER
CO. FILE NO. 251-49

FEB 16 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, or by.....

..... Student Embalmer No.
working under my personal supervision.

Signed.....
Student Embalmer

Signed *C. J. Lovberg*
Licensed Embalmer No. *3810*
P. O. Address *Cape Girardeau, 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.