

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39827

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 296 PRIMARY REG. DIST. NO. 6019 Registrar's No. 19

890  
1

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

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>RAY</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>RAY</u>  |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL 3mi. E. ORRICK</u> c. LENGTH OF STAY (in this place) <u>LIFE</u>  |                               | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ORRICK 3mi. E. 0-90</u>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>HOME</u>   |                               | d. STREET ADDRESS (If rural, give location) <u>3mi. E. of ORRICK</u>   |   |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>JESS</u> b. (Middle) <u>RASTUS</u> c. (Last) <u>CLAYPOLE</u>   |                               | 4. DATE OF DEATH (Month) (Day) (Year) <u>11 19 52</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>APRIL 18 - 1882</u>   |
| 9. AGE (In years last birthday) <u>70</u> if UNDER 1 YEAR Months Days   |                               | 10. IF UNDER 24 HRS. Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>  | 11. BIRTHPLACE (City and State or Foreign Country) <u>E. of RICHMOND, MO.</u>     |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                               | 13a. FATHER'S NAME <u>AARON CLAYPOLE</u>   |   |
| 13b. MOTHER'S MAIDEN NAME <u>HULDA ISHMAEL</u>  |                               | 14. NAME OF HUSBAND OR WIFE <u>IDA MAE CLAYPOLE</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u>500-09-2972</u>   | 17. INFORMANT'S SIGNATURE OR NAME <u>MACK CLAYPOLE</u> ADDRESS <u>ORRICK, MO.</u> |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u><br>ANTECEDENT CAUSES<br>DUE TO (b) <u>Fatigue &amp; excitement</u><br>DUE TO (c) <u>Fighting grass fire</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION <u>4201</u>   |   |
| 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) (Min.)  |                               | 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. |                               |  |   |
| 23. SIGNATURE (Degree or title) <u>John F. Babers, 3</u>  |                               | 23b. ADDRESS <u>Rehoboth MO</u>  |   |
| 23c. DATE SIGNED <u>11-20-52</u>  |                               |  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 24b. DATE <u>11/22/52</u>  |   |
| 24c. NAME OF CEMETERY OR CREMATORY <u>SOUTH POINT</u>   |                               | 24d. LOCATION (City, town, or county) (State) <u>ORRICK Mo.</u>  |   |
| DATE REC'D BY LOCAL REG. <u>11-20-52</u>  |                               | REGISTRAR'S SIGNATURE <u>Helen J. Larkin</u> ADDRESS <u>Good-Bailey Orrick, Mo.</u>  |   |
| 25. FUNERAL DIRECTOR'S SIGNATURE  |                               | ADDRESS  |   |

**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 Maria D. Bailey

Licensed Embalmer No. 4887

P. O. Address Oriskany, 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.