

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

WED APR 14 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 6121 Registrar's No. 239

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Birch Tree, Mo</u>		c. LENGTH OF STAY (in days) <u>6 Months</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Birch Tree, Mo</u> <u>1010</u>	
		d. STREET ADDRESS (If rural, give location) <u>Rural</u> <u>8</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Edward</u>	b. (Middle) <u>Wondor</u>	c. (Last) <u>Clements</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 10 1953</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 8th - 81</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 Mts. Hours
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>West Branch Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charley Clements</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca John</u>	14. NAME OF HUSBAND OR WIFE <u>Margaret Clements</u>
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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. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Margaret Clements</u> ADDRESS <u>Birch Tree, 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of Stomach</u> <u>Apoplexy</u>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.	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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 6 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. J. Davis M.D.</u> (Degree or title)	23b. ADDRESS <u>Birch Tree Mo</u>	23c. DATE SIGNED <u>4/10-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Feb 13 53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cem,</u>	24d. LOCATION (City, town, or county) (State) <u>Valentine Neb.</u>
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DATE REC'D BY LOCAL REG. <u>4-13-53</u>	REGISTRAR'S SIGNATURE <u>Mable Green 447</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Duncan Funeral Home</u> ADDRESS <u>Mtn View, Mo</u>
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**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 *John F. Duncan* \_\_\_\_\_

Licensed Embalmer No. *2516* \_\_\_\_\_

P. O. Address *West View 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.