

43435

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JAN 11 1954

V.S. No. 300

Rev. 10-48

BIRTH NO. <u>124</u>		REG. DIST. NO. <u>163</u>		PRIMARY REG. DIST. NO. <u>5596</u>		Registrar's No. <u>74</u>							
1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u>				b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>DE SOTO RURAL VALE</u>				c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>ST. LOUIS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u><del>BETH ELLEN</del> TERRE HYGI-EMINA</u>				e. STREET ADDRESS (If rural, give location) <u>4910 N. 20TH ST.</u>				2099 1					
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u> b. (Middle) <u>THOMAS</u> c. (Last) <u>CLEMENTS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 25 1953</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>		8. DATE OF BIRTH <u>MARCH 2 1882</u>		9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.	
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 (City and State or Foreign Country) <u>WALCOTT ARK.</u>				12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>W.M.T. CLEMENTS</u>				13b. MOTHER'S MAIDEN NAME <u>MARK ANN LAMB</u>				14. NAME OF HUSBAND OR WIFE <u>ROSE</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. <u>UNKNOWN</u>				17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mattie Braden Moundake Ark</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, asthenia, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Internal Head Injuries</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>One to auto Collision</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND 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) <u>050</u> (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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3p</u> m., from the causes and on the date stated above.													
23a. SIGNATURE (Degree or title) <u>V.B. Edwards M.D. Surgeon</u>				23b. ADDRESS <u>Cedar Hill Mo.</u>				23c. DATE SIGNED <u>12/26/53</u>					
24a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>DEC 26 1953</u>		24c. NAME OF CEMETERY OR CREMATORY. <u>MT. Zion CEM</u>		24d. LOCATION (City, town, or county) (State) <u>PARAGOULD ARK.</u>							
DATE REC'D BY LOCAL REG. <u>12-30-53</u>		REGISTRAR'S SIGNATURE <u>Marie Garrison</u>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Paragould Ark</u>							

(Licensed Embalmer's Statement on Reverse Side)

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

over 3

JEFFERSON COUNTY HEALTH DEPT.  
HILLSBORO, MISSOURI

DATE RECEIVED JAN 5 1954

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.....  
Signature of Student Embalmer

Signed.....  
*G. W. Williamson*

Licensed Embalmer No. *3575*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.