

FILED SEP 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32755

State File No.

BIRTH NO.		REG. DIST. NO. <u>322</u>		PRIMARY REG. DIST. NO. <u>6087</u>		Registrar's No. <u>27</u>		
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>R.F.D. Slater</u>		c. LENGTH OF STAY (in this place) <u>80 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>R.F.D. No. 1, Slater</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION XXXXXXXXXXXXXXXXXXXX				d. STREET ADDRESS (If rural, give location) <u>0970</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Marion</u> b. (Middle) <u>Sparks</u> c. (Last) <u>Clements</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-6-1954</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>June, 19-1890</u>		9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>17</u>	IF UNDER 12 HRS. Hours <u>0</u> Mins. <u>0</u>	
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 <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Shackleford, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>		
13a. FATHER'S NAME <u>Ervine John Clements</u>			13b. MOTHER'S MAIDEN NAME <u>Mattied Vaughan</u>		14. NAME OF HUSBAND OR WIFE <u>Catherine Clements</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Catherine Clements--Slater, Mo</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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u>	
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)		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>Sept 7, 1954</u> , 19 <u>54</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:30 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Q.L. Lawlers M.D. Coronary Specialist</u>				23b. ADDRESS <u>Marshall Mo</u>		23c. DATE SIGNED <u>9-7-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/8th 1954</u>	24c. NAME OF CEMETERY OR REPOSITORY <u>Rehoboth</u>		24d. LOCATION (City, town, or county) (State) <u>Slater, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>9/13/54</u>		REGISTRAR'S SIGNATURE <u>Mrs. Earl C. Metz</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Brothers</u>		ADDRESS <u>Slater, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

0970

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 A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Slater, 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.