

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5354**

FILED FEB 19 1957

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 5630 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, write RURAL and give town(ship) OR TOWN <u>Rural Lebanon T. S.</u>		c. CITY OR TOWN <u>Lebanon</u>	d. RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <input checked="" type="checkbox"/>		e. STREET ADDRESS (If rural, give location) <u>Rt. 3</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rt. 3</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Walter</u> b. (Middle) <u>A</u> c. (Last) <u>Claxton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 7 1957</u>		
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>Sept 28 1888</u>	9. AGE (In years last birthday) <u>68</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>Wright Co. Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>James Claxton</u>		13b. MOTHER'S MAIDEN NAME <u>Lena Palmer</u>		14. NAME OF HUSBAND OR WIFE <u>Vellie Claxton</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>487-32-2118</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. W. A. Claxton Lebanon Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Amyotrophic lateral sclerosis</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) _____			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Pro</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>3561</u>	
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 16 Jan, 1957 to 2-7, 1957, that I last saw the deceased alive on 2-7, 1957, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Paula A. Jenkins M.D.</u>		23b. ADDRESS <u>Slight Bldg. Lebanon Mo</u>		23c. DATE SIGNED <u>2-9-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/10/57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rose Memo. Park</u>	
24d. LOCATION (City, town, or county) (State) <u>Laclede Co. Mo.</u>					

DATE REC'D BY LOCAL REG. <u>2-10-1957</u>		REGISTRAR'S SIGNATURE <u>Thella L. Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HP Almeron Lebanon Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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Received 2-18-57
Laclede County Health Unit
File No. 32
Date Filed 2-18-57

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 Stanley R. Palmers

Licensed Embalmer No. 14810

P. O. Address Lebanon

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.