

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH242276
STATE FILE NUMBER

FILED JUL 23 1957

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u>			Length of stay in 1b <u>70 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>Alden St</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ellen Clinkenbeard</u>				4. DATE OF DEATH Month Day Year <u>7-13-1957</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-4-1876</u>		9. AGE (In years last birthday) <u>81</u>	FUNDER YEAR Months Days <u>5 9</u>	IF UNDER 24 HRS. Hours Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>Brush Creek Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>u.s.</u>		
13a. FATHER'S NAME <u>William H. Cruzan</u>			13b. MOTHER'S MAIDEN NAME <u>Marietta Liggett</u>			14. NAME OF HUSBAND OR WIFE <u>Oren Clinkenbeard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Olive Clinkenbeard Bethany, Mo</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>General Debility</u>		DUE TO (c) <u>9020</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture Neck 7 Rt Femur 9-27-56</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fall from bed in home 241</u>						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>6:30 p.m. 9-27-56</u>									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Bethany</u>		COUNTY <u>Harrison</u>		STATE <u>Mo</u>	
21. I attended the deceased from <u>9-27-56</u> to <u>7-13-57</u> and last saw her alive on <u>7-13-57</u> Death occurred at <u>7-13-57</u> <u>5:30</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Gullert H. Throggs DO</u>				22b. ADDRESS <u>Bethany Mo</u>				22c. DATE SIGNED <u>7-18-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-15-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Missouri</u>			23d. LOCATION (City, town, or county) (State) <u>Bethany Mo</u>			
24. FUNERAL DIRECTOR <u>McKean Bethany Mo</u>				25. DATE RECD. BY LOCAL REG. <u>7-18-57</u>		26. REGISTRAR'S SIGNATURE <u>Jella Mayes</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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OCT 17 1957

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 *MBH*

Licensed Embalmer No. 3899

P. O. Address Bethany, Md

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.