

FILED OCT 8 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34674

STATE FILE NUMBER

Registration District No. 378 Primary Registration District No. 6296 Registrar's No. 41

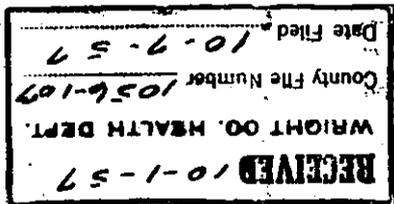
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1. PLACE OF DEATH a. COUNTY <u>Wright</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>MO</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wood Township</u>		c. CITY OR TOWN <u>Wright</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>RT # 3</u>	
3. NAME OF DECEASED (Type or print) <u>F. M. E. Lloyd E. Clapsaddle</u>		4. DATE OF DEATH <u>Sept 19, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OF HAIR <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5, 1874</u>
9. AGE (In years) <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (City and state or country) <u>Wright, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Henry Clapsaddle</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Dodge</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary Jane Clapsaddle</u> Address <u>Wright, 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>Atherosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4500</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
21. I attended the deceased from <u>June 10-57</u> to <u>Sept. 19-1957</u> and last saw him alive on <u>Sept. 18-1957</u> Death occurred at <u>2135 R.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R.M. Murray M.D.</u> (Degree or title)		22b. ADDRESS <u>Wright, Mo</u>	
22c. DATE SIGNED <u>9-20-57</u>		23a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>Buried</u>	
23b. DATE <u>9-21-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Old Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Wright, Mo.</u>		24. FUNERAL DIRECTOR <u>Hugh Windl</u> ADDRESS <u>Wright, Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>9-23-57</u>		26. REGISTRAR'S SIGNATURE <u>A.B. Ames</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



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 *Frank Grabel* .....

Licensed Embalmer No. *4140* .....  
P. O. Address *State St* .....

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.