

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **739**

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY City of St. Louis				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Missouri b. COUNTY Scott					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		c. CITY OR TOWN Chaffee		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Memorial Hospital For Children			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rt. #2		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Cecil Middle Leon Last Clayborn				4. DATE OF DEATH Month January Day 21 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/5/60		9. AGE (last birthday) IF UNDER 1 YEAR: Months 3 Days 16 IF UNDER 24 HR: Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Cecil Clayborn			13b. MOTHER'S MAIDEN NAME Leona Lankford			14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. None		17. INFORMANT Name Cecil Clayborn Sr. Address Chaffee, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal Insufficiency, Duodenal Ulcer DUE TO (b) Pneumonia, Cleft Palate - Protruding Mandible (Robin Syndrome) DUE TO (c) 274x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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 Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 28 Dec 1960 to 22 Jan 1961 and last saw her/him alive on 21 Jan 1961 Death occurred at 5:30 pm 21 Jan 1961 m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) James H. Sullivan M.D.				22b. ADDRESS		22c. DATE SIGNED 1/22/61			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-23-61		23c. NAME OF CEMETERY OR CREMATORY Ferret Hills Mem. Cms.		23d. LOCATION (City, town, or county) Scott County, Mo.			
24. FUNERAL DIRECTOR Werner Funeral Home Ash Grove				25. DATE RECD. BY LOCAL REG. JAN 24 1961		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

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 Not Embalmed, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. D. May

Licensed Embalmer No. 4640

P. O. Address Adrian, Mich

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.