

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007260  
STATE FILE NUMBER

Registration District No. 334 Primary Registration District No. 2072 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>27 days</u>	c. CITY OR TOWN <u>Carrollton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>John Fitzgibbon Memorial</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route # 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Samuel</u> Last <u>Clement</u>			4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1961</u>		
5. SEX <u>Male</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>3/28/78</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>	11. BIRTHPLACE (City and state or country) <u>Wakenda, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas Milton Clement</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Frances Winfrey</u>	14. NAME OF HUSBAND OR WIFE <u>Sally Mae Adkins</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.	17. INFORMANT <u>Frances C. Anderson</u> Address <u>Carrollton, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Right middle &amp; lower lobe pneumonia</u>		<u>4 weeks</u>
DUE TO (b) <u>Cerebral thrombosis</u>		<u>5 weeks</u>
DUE TO (c) <u>Cerebral arterio sclerosis</u>		
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 type="checkbox"/> NO <input checked="" 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 <u>Carrollton, Mo</u>	COUNTY <u>Carroll</u>	STATE <u>Mo</u>
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21. I attended the deceased from Jan 22, 61 to 2/14/61 and last saw <sup>her</sup>him alive on 2/14/61  
Death occurred at 1:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Maurice E. Fisher Esq</u> (Degree or title)	22b. ADDRESS <u>Marshall, Mo</u>	22c. DATE SIGNED <u>2/14/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/17/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Willis Chapel Cem.</u>	23d. LOCATION (City, town, or county) <u>Carroll County, Mo</u> (State)
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24. FUNERAL DIRECTOR <u>Gibson Funeral Home, Carrollton, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-16-61</u>	26. REGISTRAR'S SIGNATURE <u>Carl J. Lead</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF MEDICAL CERTIFICATION

**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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.