

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048094

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 540

FILED JAN 3 1962		
1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Frankclay</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u> c. CITY OR TOWN <u>Frankclay</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Hwy M.</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Price</u> Last <u>Clinton</u> 4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1962</u>		
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH <u>3-9-1882</u> 9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist - Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Nelson Mfg. Co.</u> 11. BIRTHPLACE (City and state or country) <u>Iron Mountain, Mo.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Clinton</u> 13b. MOTHER'S MAIDEN NAME <u>(Unknown)</u> 14. NAME OF HUSBAND OR WIFE <u>Hattie Clinton</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> 17. INFORMANT <u>Bud Downey, Frankclay, Mo.</u> Address _____		
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>Pneumonia Labor</u> DUE TO (b) <u>Possible pulmonary Tuberculosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2-3 yrs</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 _____ COUNTY _____ STATE _____	21. I attended the deceased from <u>1959</u> to <u>Dec 27, 1962</u> and last saw ^{her} him alive on <u>Dec 25, 1962</u> Death occurred at <u>1300</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>J.L. Foster MD</u> (Degree or title) 22b. ADDRESS <u>Deslog, Mo</u> 22c. DATE SIGNED <u>12-27-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 23b. DATE <u>12-27-1962</u> 23c. NAME OF CEMETERY OR CREMATORY _____ 23d. LOCATION (City, town, or county) <u>Edwardsville, Ill.</u> (State) _____	24. FUNERAL DIRECTOR <u>Bert L. Boyer, Leadwood, Mo.</u> ADDRESS _____ 25. DATE RECD. BY LOCAL REG. <u>Dec 27, 1962</u> 26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59
 10940
 20940
 3
 4 0
 5 1
 6
 7 0
 8 2
 9 002.1
 10
 11
 12 90-0
 13 1-0

USE BLACK INK OR TYPEWRITER RIBBON

JAN 9 1963

JAN 30 1963

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 Bert L. Boyer

Licensed Embalmer No. 3448

P. O. Address Leadwood, Mo.

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.