

Registration District No. 347 Primary Registration District No. 3018 Registrar's No.

1. PLACE OF DEATH:  
(a) County Henry, Mo  
(b) City or town Clinton, Mo  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) ✓  
(d) Length of stay: In hospital or institution 33 yrs (Specify whether years, months or days) 1

3. (a) PRINT FULL NAME Clint Charles Massingale  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color of race White (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 18 1906 (Month) (Day) (Year)

8. AGE: Years 33 Months 4 Days 13 If less than one day hr. min.

9. Birthplace Clinton, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Clinton Massingale  
13. Birthplace Clinton, Mo. (City, town, or county) (State or foreign country)

14. Maiden name Lucie Boyson  
15. Birthplace Clinton, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. F. Massingale  
(b) Address 806-11-4th

17. (a) Burial (b) Date thereof 4 3 1940 (Month) (Day) (Year)  
(c) Place: burial or cremation Colooid Cemetery

18. (a) Signature of funeral director Spencer Son  
(b) Address Clinton, Mo.

19. (a) 4-6-40 (b) Dr. J. P. Hamilton (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Henry  
(c) City or town Clinton (If outside city or town limits, write "RURAL")  
(d) Street No. 806-11-4th (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1st year 1940 hour 5 minute - 1 M.  
21. I hereby certify that I attended the deceased from April 1 1940, to April 1 1940; that I last saw him alive and that death occurred on the date and hour stated above.

Immediate cause of death Death due to natural cause from history - investigation  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration many years

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy ✓

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) ✓  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 317 (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature S. B. Hatcher (M. D. or other) Dr. D.  
Address Coverly, Clinton, Mo. Date signed 4/13/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

2002

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*Irvin H. Anderson*

Licensed Embalmer No. *3641*

P. O. Address *Clinton, 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 this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11084

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Clinton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days (Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Clinton Charles Massingale

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race col

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

(Month) (Day) (Year)

8. AGE:

Years 33 Months 4 Days 13  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Clinton Massingale

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 4 day 1 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. B. Hughes (M. D. or other) \_\_\_\_\_

Address Clinton Mo Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11084

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) **PRINT FULL NAME** Chas Massingale

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race cal 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	33	4	13	h. min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

{ 13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

{ 14. Maiden name \_\_\_\_\_

{ 15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

20. DATE OF DEATH: Month apr day 1 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death: Death due to natural causes from history investigation

Due to \_\_\_\_\_

Due to History suggestive of myocardial infarction

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. B. Hunshead (M.D. or other) \_\_\_\_\_

Address Clinton \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL