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FILED JAN 20 1948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **892**
Registrar's No. **10**

Registration District No. **137**

Primary Registration District No. **3029**

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:
at home 111 S. 4th St. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community **65 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Henry** **411**
(c) City or town **Clinton** **1**
(If outside city or town limits, write "RURAL") **2**
(d) Street No. **111 S. 4th St** **3**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **no** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **15**
year **1948** hour **7** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **Oct 20**
19 **42** to **Jan 15** 19 **48**
that I last saw her alive on **Jan 15** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death

Chraemia
Due to **Chronic Myocarditis**
Due to **Arterial Sclerosis**

Other conditions
(include pregnancy within 3 months of death)

Major findings:
Of operations **(1)**
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 **Ed. C. Peltor** (M. D. brother)
Address **Clinton Mo** Date signed **1/16/48**

3. (a) PRINT FULL NAME **EFFIE CECIL**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Aug 29 - 1865**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 4 14 hr. _____ min.

9. Birthplace **Windsor** **no**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Keeper**

11. Industry or business _____

12. Name **Wellington Gray**

13. Birthplace **unknown** **7**
(City, town, or county) (State or foreign country)

14. Maiden name **Agnes Head**

15. Birthplace **Clinton** **no**
(City, town, or county) (State or foreign country)

16. (a) Informant **Effie Cecil**

(b) Address **Clinton Mo**

17. (a) **Rural** (b) Date thereof **1-18-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Englewood Cem**

18. (a) Signature of funeral director **Conalust Peck**

(b) Address **Clinton Mo**

19. (a) **1-17-48** (b) **P. R. Kenney**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED
District Health Officer No. 7,
District File Number 13-47-5042
Date Filed 1-18-48

JAN 28 1948

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 R R Kenney
Licensed Embalmer No. 3099
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, fact should be so stated above.