

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36842

State File No. _____

No. 300
10. 48

FILED DEC 5 1950

BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 4217 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Urich</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Urich</u> <u>1420</u>	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Edith</u> b. (Middle) <u>Odelia</u> c. (Last) <u>Clinton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11-21-1950</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>Jul 29 1889</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>near Urich Missouri</u>	
13a. FATHER'S NAME <u>Wm Edward Shelton</u>			13b. MOTHER'S MAIDEN NAME <u>Emily Caroline Mason</u>		14. NAME OF HUSBAND OR WIFE <u>J. W. Clinton</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No. no. on service) (If yes, give war or dates of service) <u>0</u>		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT'S SIGNATURE OR NAME <u>J. W. Clinton</u> ADDRESS <u>Urich Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of Breast</u>				INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>General debility</u>				
		DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death. <u>195X</u>				
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>48</u> , to <u>Nov. 21</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>50</u> , and that death occurred at <u>5. 45</u> a. m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Dr. J. W. Galford</u> (Degree or title) <u>Mo.</u>		23b. ADDRESS <u>Urich Mo</u>		23c. DATE SIGNED <u>Nov 23-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>0</u>		24b. DATE <u>Nov-23-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Urich Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Urich Mo.</u>	
DATE REC'D BY LOCAL REG <u>Nov-23-50</u>		REGISTRAR'S SIGNATURE <u>Florence Oclair</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Brown</u> ADDRESS <u>Urich Mo</u>	

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

RECEIVED 17/4/50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 12-4-50

APR 14 1950

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 _____
Student Embalmer

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.