

MAR 21 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

Wiley
File No. 5899

Registered No. 46
St. _____ Ward _____

1. PLACE OF DEATH

County *Pettis*
Township *Sedalia*
City *Sedalia* (No. *420*)

Registration District No. *668*
Primary Registration District No. *3082*
J. Luncy

2. FULL NAME

Mr. Oliver W. Clabough

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 14 - 1867*

7. AGE YEARS *60* MONTHS *9* DAYS _____ IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Physician*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Ohio
(STATE OR COUNTRY)

10. NAME OF FATHER

Samuel Clabough

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Ohio
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Margaret Gregory

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ohio
(STATE OR COUNTRY)

14. INFORMANT

Mrs. Mrs. O. W. Clabough
(Address) *Sedalia, Mo.*

15. FILED

2-25-28
J. S. Love
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 13 1928*
17. I HEREBY CERTIFY, That I attended deceased from *Feb 13 1928* to *Feb 13 1928*

that I last saw him alive on *Feb 13 1928*, and that death occurred, on the date stated above, at *6:30 a.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Coronary Embolism

CONTRIBUTORY (SECONDARY)

Myocardial Infarction
Ruptured Ventricle

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

19. DID AN OPERATION PRECEDE DEATH?

no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. E. Hunt* M. D.
, 19 (Address) *Sedalia, Mo.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

La Monte, Mo.

DATE OF BURIAL

Feb 15 1928

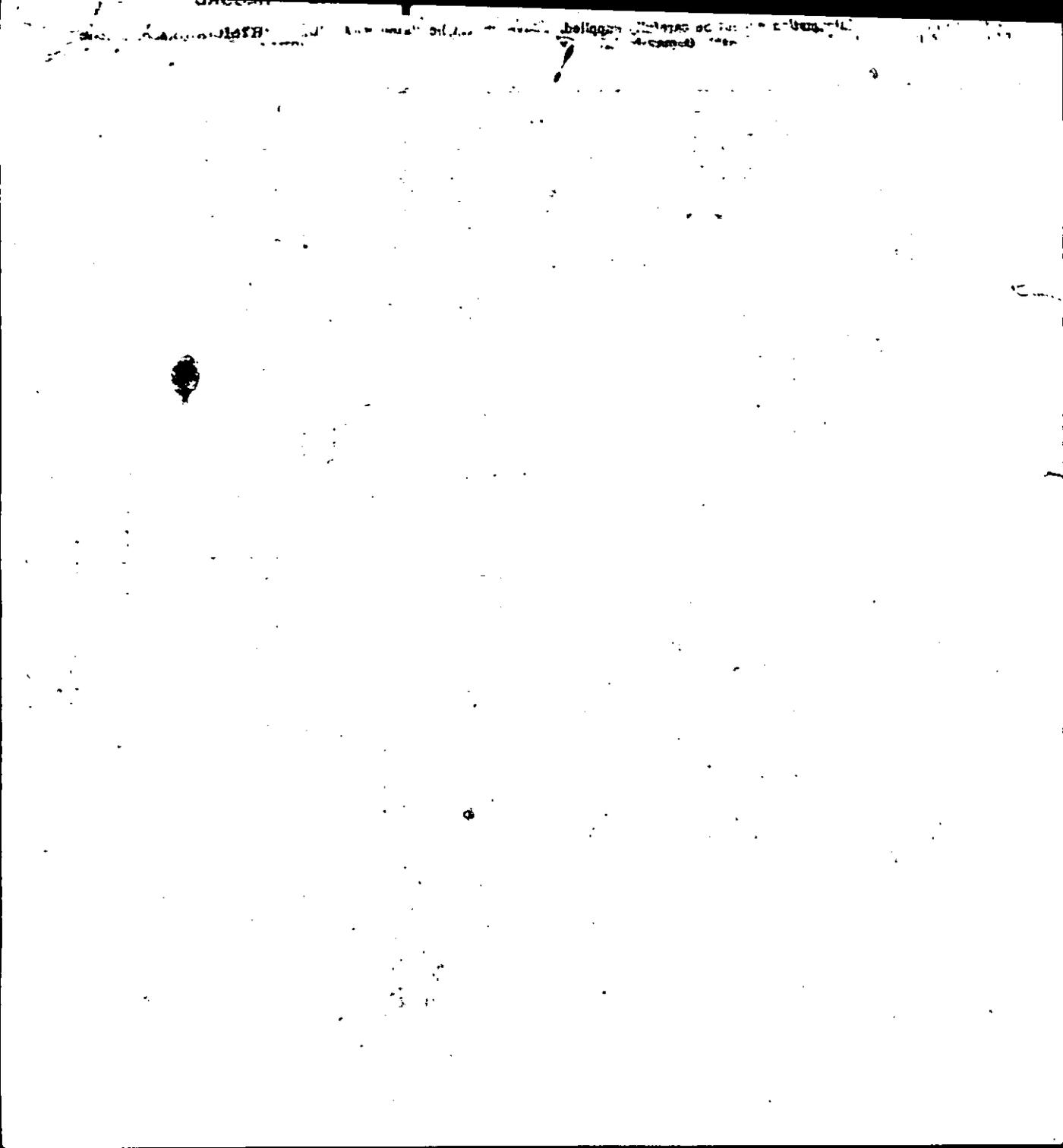
20. UNDERTAKER

Gillespie

ADDRESS

Sedalia

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.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Pettis Registration District No. 668 File No. _____
 Township _____ Primary Registration District No. 3032 Registered No. 46
 City Sedalia (No. 420 S. Quincy) St. _____ Ward _____

2. FULL NAME Dr. Omer W. Clabaugh

(a) Residence. No. _____ St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-14-1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
59 9 _____

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 13 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____
 WAS THERE AN AUTOPSY: _____
 WHAT TEST CONFIRMED DIAGNOSIS: _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT _____ (Address) _____

15. FILED 2-25 1928 J. L. Lou REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

