

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

Do not use this space.

16787

1. PLACE OF DEATH
 64 County Marion Registration District No. 542
 1 Township Marion Primary Registration District No. 3829
 8 City Hannibal (No. Stellwell place #9) St. _____ Ward _____
 2. FULL NAME George D. Clayton
 (a) Residence. No. Stellwell place #9 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.

File No. _____
 Registered No. 160
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF _____
 (OR) WIFE OF Mary
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 2nd 1860
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
72 9 17
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Real Estate
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) New London
 (STATE OR COUNTRY) Mo
 10. NAME OF FATHER Charles H. Clayton
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia
 (STATE OR COUNTRY) Mo
 12. MAIDEN NAME OF MOTHER Elizabeth Hays
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) New London
 (STATE OR COUNTRY) Mo

14. INFORMANT Robert Clayton
 (Address) Hannibal Mo
 15. May 31 1932 E. Causers
 FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25th 1932
 17. I HEREBY CERTIFY, That I attended deceased from July, 1932, to May 24, 1932
 that I last saw him alive on May 24, 1932, and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Failure
92A 92A
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Chronic mitral regurgitation
 (SECONDARY) (duration) 20 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.
 DID AN OPERATION PRECEDE DEATH? No. DATE OF ①
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) W. H. Hays, M. D.
 , 19 (Address) Hannibal 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 DATE OF BURIAL
Int Olivet Cemetery 5/26/1932
 20. UNDERTAKER* James O'Donnell ADDRESS Hannibal Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. E.—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.

981 C-2 1932

