

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.

JAN 15 1940
Registration District No. 8

Primary Registration District No. 4003

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town Amazonia
(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 20 yrs.
years, months or days

3. (a) PRINT FULL NAME Harry Clairmont
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color or race w 6. (a) Single, widowed, married, divorced w
6. (b) Name of husband or wife deceased (c) Age of husband or wife if alive 1267 years
7. Birth date of deceased 3 15 (Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Debuque Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Coop.

11. Industry or business Coop.

MOTHER FATHER
12. Name unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Joseph R. Bader
(b) Address Amazonia Mo

17. (a) Burial (b) Date thereof 12-26-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Amazonia Mo

18. (a) Signature of funeral director B. C. Bader
(b) Address Amazonia Mo

19. (a) 12-24-1939 (b) Mrs. J. W. Hollins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrew
(c) City or town Amazonia Mo
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 21
year 1939 hour 9 minute 35 p. M.

21. I hereby certify that I attended the deceased from Apr. 1st, 1939, to Dec. 21, 1939;
that I last saw him alive on Dec. 21, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular
dysfunction and Aneurysm Duration 10 months
190 or longer

Due to Quality + Specific
blood

Due to _____

Other conditions High blood pressure
(Include pregnancy within 3 months of death)

Major findings:
Of operations 8/10
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? no
(e) Means of injury _____
While at work? _____ (Specify type of place)

28. Signature J. B. Bover (M. D. or other) _____
Address Amazonia Mo Date signed 12/22/39

RECEIVED

District Health Officer No. 11;

District File Number

140-1876

Date Filed

JAN 11 1940

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.....

me

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

working under my personal supervision.

Signed.....

E. C. Breit

Licensed Embalmer No.....

2650

P. O. Address.....

Savannah Ga

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.