DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED MAR 14 1940

State File No. 5907

Registration District No. 76 — Primary Registration District No. 5110 B — Registrar's No. 3

1. PLACE OF DEATH:

(a) County Boone [illegible]

(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Near-Claysville, Mo (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 20 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. Near-Claysville & Hartsburg (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Sarah Francis Pryor Clardy

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sterling Clardy 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased 10 (Month) 17 (Day) 1867 (Year)

8. AGE: Years 72 Months 3 Days 15 If less than one day ____ hr. ____ min.

9. Birthplace Wippowill - Montgomery Co. Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ____

FATHER
12. Name Henry Pryor
13. Birthplace Montgomery Co. Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lucinda Katchersize
15. Birthplace Montgomery Co. Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sterling Clardy

(b) Address Hartsburg Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/40 (Month) (Day) (Year)

(c) Place: burial or cremation Family Cem. on farm

18. (a) Signature of funeral director Buescher Funeral Home

(b) Address Jefferson City, Mo.

19. (a) 2/7/40 (Date received local registrar) (b) H. A. Wimmer 77 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2 year 1940 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1-19-1940 to 2-2-1940, 1940 to ____, 1940 that I last saw her alive on 2-1-1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to Influenza	
Due to	
Other conditions Cancer of Stomache Carcinoma (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature C. P. Meyer (M. D. or other)

Address Hartsburg Date signed 2-5-1940

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Rev. 5-17-39 I X19511

Dr
CP Moya

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 Victor Buescher

Licensed Embalmer No. 3701

P. O. Address J. C. 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, above space should be left blank.