

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

.6123  
Do not use this space.

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.

FILED MAR 11 1940

1. PLACE OF DEATH  
 (a) County Collaway Registration District No. 104  
 (b) Township 3 Primary Registration District No. 3008 Registered No. 35  
 (c) City Fulton (d) Street No. State Hospital #1 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 5 yrs. 7 mos. 20 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles Clancy  
 (a) Residence, No. Roman City, Mo.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DK.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>80 approx</u>	<u>DK</u>	<u>DK</u>	<u>DK</u>	<u>DK</u>

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) Labour  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa, I

FATHER  
 13. NAME DK  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio, I

MOTHER  
 15. MAIDEN NAME DK  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK

17. INFORMANT (ADDRESS) State Hosp. #1 Fulton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Columbia, Mo. 2-5-40 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. B. Roberts Columbia Mo.

20. FILED Feb. 5, 1940 R. N. Crews Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-3-40

22. I HEREBY CERTIFY, That I attended deceased from 6-30, 1938, to 2-3, 1940  
 I last saw him live on 2-2, 1940. Death is said to have occurred on the date stated above, at 10:00 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Arteriosclerosis and hypertension  
 Date of onset

Other contributory causes of importance:  
Psychosis, dehydration, malnutrition

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) Geo. J. Wood, M. D.  
 106 (Address) State Hosp #1 Fulton Mo.

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**