

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7596
Registrar's No. 4

Registration District No. 617 Primary Registration District No. 5818

1. PLACE OF DEATH:

(a) County Modaway
(b) City or town Barnard *wh. Barnard*
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution (Specify whether years, months or days) Entire Life
In this community Entire Life

3. (a) PRINT FULL NAME THOMAS EDGAR CLISER

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife LOTTIE CLISER 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased. NOV 24 1971
(Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 4 If less than one day hr. _____ min. _____

9. Birthplace BARNARD MO
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER
12. Name MATTHEW CLISER
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 Lottie Cliser
(b) Address Barnard, Mo.

17. (a) SALEM (b) Date thereof March 1-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation SALEM CEMETERY

18. (a) Signature of funeral director J. Fred Truhme
(b) Address Savannah, Mo.

19. (a) 3/1/40 (b) Chas. Humber
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Modaway
(c) City or town Barnard Rural
(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 Feb day 28
year 1940 hour 7 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 6-1-39
_____, 19____, to 2-28, 1940
that I last saw him alive on 2-28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Prostate
Diagnosed Myocarditis
Due to with hypertension
and uremia
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
51

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: Of operations _____
Of autopsy _____

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? 517
_____, _____ (Specify type of place)
While at work _____ (e) Means of injury _____
Signature W.R. Jackson (M. D. or other) _____
Address Manlyville, Mo Date signed 3-1-40

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.

RECEIVED

District Health Officer No. 11;
District File Number 342-336
Date Filed 3-12-40

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.....

J. Fred Turbine, Registered Apprentice No.....
working under my personal supervision.

Signed J. Fred Turbine
Licensed Embalmer No. 1279
P. O. Address Savannah

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.