

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11273

Registration District No. 408

Primary Registration District No. 3020

Registrar's No. 56

1. PLACE OF DEATH:

- (a) County Jasper
 (b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution M'Gune-Brooks Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
(Specify whether)

In this community
years, months or days 0 1

3. (a) PRINT FULL NAME CLINT DAUGHERTY

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased November 9 1879
(Month) (Day) (Year)

8. AGE: Years 60 Months 3 Days 25 If less than one day
hr. min.

9. Birthplace Carthage Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Bookkeeper - Bank

11. Industry or business (Retired)

MOTHER FATHER { 12. Name James F. Daugherty
 13. Birthplace Lee County Virginia
(City, town, or county) (State or foreign country)
 14. Maiden name Lillian M. Daugherty
 15. Birthplace Buchanan Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature F. E. Daugherty

(b) Address 1603 Vance Memphis Tenn

17. (a) Cremation (b) Date thereof Mar 6 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director F. W. D. ...

(b) Address Carthage Mo.

19. (a) Mar 6 1940 (b) E. G. M. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Jasper
 (c) City or town Carthage
(If outside city or town limits, write "RURAL")
 (d) Street No. 831 Clinton
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4
 year 1940 hour 11 minute 20 P. M.

21. I hereby certify that I attended the deceased from Feb 25, 1940, to Mar 4, 1940;
 that I last saw him alive on Mar 4, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 8 days

Due to Hypertension - Cardiovascular disease 7

Due to _____
 Other conditions none
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: none
 Of operations none
 Of autopsy none
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 4
 (c) Where did injury occur? 2 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature George H. Wood (M. D. or other) _____
 Address Carthage Mo Date signed 3/27/40

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.

MO-5-17-39 1-118511

RECEIVED

District Health Officer No. 6,

District File Number 440-1183

Date Filed APR 15 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

P. W. K. Miller

Licensed Embalmer No.....

814

P. O. Address.....

Carthage 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.