

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26157
Registrar's No. 962

Registration District No. 272 Primary Registration District No. 4463

1. PLACE OF DEATH: St. Francois Co. Mo
(a) County
(b) City or town Edwards Mo
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community: 2 years (years, months or days)

3. (a) PRINT FULL NAME: Lloyd Maude Clemens
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex: Male 5. Color or race: White 6. (a) Single, widowed, married, divorced: _____
6. (b) Name of husband or wife: Burt Clemens 6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: Oct 31 1892
(Month) (Day) (Year)

8. AGE: Years 47 Months 8 Days 26 If less than one day hr. min.

9. Birthplace: Knob Lick Mo
(City, town, or county) (State or foreign country)

16. Usual occupation: House Wife
11. Industry or business: at home

MOTHER FATHER
12. Name: James Black
13. Birthplace: Knob Lick Mo
(City, town, or county) (State or foreign country)
14. Maiden name: Catherine Chapman
15. Birthplace: Knob Lick Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Maude Clemens
(b) Address: Edwards Mo

17. (a) Burial (b) Date thereof: 7-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Woodlawn

18. (a) Signature of funeral director: Sparks
(b) Address: Edwards

19. (a) 7-27-40 (b) O. B. Turner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: St. Francois
(c) City or town: Edwards
(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 July, day 27, year 40 hour _____ minute 10:35 P
21. I hereby certify that I attended the deceased from 7-24 to 7-27, 1940
that I last saw him alive on 7-26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Breast
Duration: _____
Due to: _____
Due to: _____
Other conditions: 5
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
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? 697
While at work? _____ (Specify type of place) (e) Means of injury _____
28. Signature: [Signature] (M. D. or other) _____
Address _____ Date signed _____

WHILE FILLING IN—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.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26 157

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 772

Primary Registration District No. 4463

Registrar's No.

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

1. PLACE OF DEATH: St. Francois
 (a) County St. Francois
 (b) City or town St. Francois
 (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 _____ (Specify whether _____)
 years, months or days)

3. (a) PRINT FULL NAME Floyd Maud Clemens
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

8. AGE: Years Months Days If less than one day
47 8 20 _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 8/2/40 (b) C. Blum
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (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.

20. DATE OF DEATH: Month July day 27
 year 1940 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
 that has been alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Breast Scirrhus 2 yrs
 Due to _____
 Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
 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? _____

While at work _____ (Specify one of place) (c) Means of injury _____
 23. Signature C. Blum (M. D. or other) _____
 Address Flat River Date 8/2/40
MO

SUPPLEMENTARY

