

1949 OCT 23 1949

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32849

Registration District No. 677 Primary Registration District No. 440-3 Registrar's No. 109

1. PLACE OF DEATH
(a) County Phelps
(b) City or town Rella
(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 2
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Edward Clayton
3. (b) If veteran, name war. No. 3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Martha 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan 11, 1881 (Month) (Day) (Year)

8. AGE: Years 89 Months 7 Days 19 If less than one day hr. min.

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

10. Usual occupation Farmer Retd 9

11. Industry or business

MOTHER FATHER
12. Name Dent 9
18. Birthplace Know 9
14. Maiden name Dent
15. Birthplace Know (City, town, or county) (State or foreign country)

16. (a) Informant R. S. Muel
(b) Address Rella Mo

17. (a) (Burial, cremation) (b) Date thereof Aug 31, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Rella

18. (a) Signature of funeral director Muel
(b) Address Rella Mo

19. (a) (Date recorded local registrar) (b) Jos. F. Myers (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Phelps
(c) City or town Rella
(If outside city or town limits, write "RURAL")
(d) Street No. Walnut St
(If rural, give location)
(e) If foreign born, how long in U. S. A? years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 30
year 1940 hour 3:30 a minute M.

21. I hereby certify that I attended the deceased from Aug 20 1940, 19 to Aug 29, 1940 that I last saw him alive on Aug 29, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration

Due to old age of 89
Due to natural causes

Other conditions (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? Lolo

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

23. Signature H.A. Davis M.D. (M. D. or other)
Address Rella Mo Date signed 9-7-40

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

RECEIVED

District Health Officer No. 5,

District File Number 1040981

Date Filed 2/12/19

Leg. 1/11/19
1/11/19

Actual burial

Actual

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

S. L. Reed

Licensed Embalmer No.

3294

P. O. Address

Racine

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.