

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 FEB 14 1941

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

Do not use this space.

2210

1. PLACE OF DEATH

County Chariton
Township Keytesville
City (No. 7)

Registration District No. 171
Primary Registration District No. 5-237

File No. 3
Registered No. 3
St. 71 Ward

2. FULL NAME

Jim Clarkson
(a) Residence, No. 2 County Infirmary St. 0 Ward 0
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed 2.

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. About 81

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 9

13. NAME unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

17. INFORMANT (ADDRESS) John Rodgers Keytesville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Triplitt DATE Jan. 16 1941

19. UNDERTAKER (ADDRESS) Geo. B. Winkelmeyer Salisbury, Mo.

20. FILED 1-15 1941 Mr. Ray Pastore Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 15 1941

22. I HEREBY CERTIFY that I attended deceased from Jan. 11 1941 to Jan. 14 1941
I last saw him alive on Jan. 14 1941. Death is said

to have occurred on the date stated above, at 12:15 a.m.
The principal cause of death and related causes of importance were as follows:

Chronic myocarditis (arteriosclerotic)
Generalized arteriosclerosis

Date of onset 7

Other contributory causes of importance: 93 h

Name of operation _____ Date of _____

What test confirmed diagnosis? None Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ 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) L. H. Hooper M. D.
(Address) Salisbury Mo.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-4-41

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 2210

Registration District No. 171

Primary Registration District No. 2237

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Keytesville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Co. Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Jim Clarkson

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

4. Sex m 5. Color or race negro 6. (a) Single, widowed, married, divorced wid
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 abt 8 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business none

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 15
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
19 _____ to _____ 19 _____;
that I saw him _____ alive on _____ 19 _____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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? _____

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

23. Signature J. L. Harms (M. D. or other) _____

Address Salisbury Date signed _____

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

BOVENA MORRIS

SUPPLEMENTARY

