

FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3701

State File No. _____

Registration District No. 653

Primary Registration District No. 45871

Registrar's No. 12

78000

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

1. PLACE OF DEATH:

(a) County. Remiscot
 (b) City or town. Braggadocio Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Little Farm Township
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 (Specify whether
 In this community years, months or days)

3. (a) PRINT FULL NAME Sarah R. Clayton

8. (b) If veteran, name war none 8. (c) Social Security No. none

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

6. (b) Name of husband or wife Clayton 6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Nov. 24-1862
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
<u>78</u>	<u>2</u>	<u>8</u>	hr. _____ min.

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

10. Usual occupation aged Housewife

11. Industry or business _____

12. Name allan. Vaughn

13. Birthplace Ky.
(City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant Harold Clayton

(b) Address St. Louis, Mo. No. 1

17. (a) Burial (b) Date thereof 2-2-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles Culp Cem

18. (a) Signature of funeral director E. J. Burns

(b) Address Warrensburg, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Remiscot
 (c) City or town Braggadocio Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 2 Miles South
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2
 year 1941 hour 12:45 minute 2 A. M.

21. I hereby certify that I attended the deceased from 1-27
 1941, to 2-2, 1941;
 that I last saw h. alive on 2-1, 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
myocardial insufficiency
 Due to _____

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

Major findings: Of operations _____
 Of autopsy _____

Duration _____
 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?

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

23. Signature Coffline (M. D. or other) D
 Address Wayle, Mo. Date signed 2-2-41

2-41-14

15-3-
6-1

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.

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Registration District No. 653

Primary Registration District No. 5871

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Peru
(b) City or town Braggadocia
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Sarah R. Clayton

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

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 78 Months 2 Days 8 If less than one day _____ 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) 2/2/41 (b) Pearl Kelley
(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 Feb day 2
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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 A. G. Shurey (M. D. or other) _____
Address Hayti Date signed _____

SUPPLEMENTARY

