

4-13-40
-17-39
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Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH

(a) County **BUCHANAN**

(b) City or town **ST. JOSEPH**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **STATE HOSPITAL No. 2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 hrs 50 min** (Specify whether years, months or days)

In this community **4 hrs 50 min**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lunington**

(c) City or town **Chillicothe**
(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.? **0** years.

3. (a) PRINT FULLNAME **Walter A. Clapper**

3. (b) If veteran, name war. _____

3. (c) Social Security No. **NONE**

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

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

7. Birth date of deceased **Unknown 1857**
(Month) (Day) (Year)

8. AGE: Years **84** Months **?** Days **?** If less than one day _____ hr. _____ min.

9. Birthplace **Unknown** **G**
(City, town, or county) (State or foreign country)

10. Usual occupation **Painter**

11. Industry or business _____

MOTHER FATHER

12. Name **Unknown**

13. Birthplace **Unknown** **G**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown** **G**
(City, town, or county) (State or foreign country)

16. (a) Informant **Chick Livingston, County**

(b) Address **Chillicothe Mo**

17. (a) **Removal** (b) Date thereof **6-25-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chillicothe Mo**

18. (a) Signature of funeral director **Merwin Shyers**

(b) Address **Chillicothe**

19. (a) **6/25/41** (b) **H. J. Hellebrugh**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **24** year **1941** hour **2** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **June 24 10 AM** to **June 24 2:50 P.M.** 19____, to _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Branchiopneumonia** **1 day**

Due to **Heart Disease** **?**
Arteriosclerotic

Due to _____

Other conditions (include pregnancy within 3 months of death) _____ **95C**

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? _____

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

23. Signature **Herbert C. Jones** (M. D. or other) **J. M. D.**
Address **1001 S. 1st St. Joe** Date signed **6-24-41**

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

11
1
7

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

Elmer Thomas

Registered Apprentice No.

working under my personal supervision.

Signed

Elmer Thomas

Licensed Embalmer No.

2640

P. O. Address

Phillip, 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, fact should be so stated above.