V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

16042

State File No.

FILED JUN 15 1942

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 4951

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days (Specify whether years, months or days)

In this community About 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. Jefferson Barracks, Mo.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country None

3. (a) PRINT FULL NAME Lois Agusta Clayton

3. (b) If veteran, name war None

3. (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 Dr. S. D. Clayton

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased September 3, 1882 (Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 2 If less than one day hr. min.

9. Birthplace De Moine, Iowa (City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business At home

FATHER
12. Name Lloyd T. Kline
13. Birthplace Penn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Madeline Vincentus
15. Birthplace Germany (City, town, or country) (State or foreign country)

16. (a) Informant Dr. S. D. Clayton
(b) Address Jefferson Barracks, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof June 7, 1942 (Month) (Day) (Year)

(c) Place: burial or cremation Muskogee, Okla.

18. (a) Signature of funeral director C. Hoffmeister U.R.C.
(b) Address 6464 Chippewa

19. (a) JUN 7 1942 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5 year 1942 hour 11 minute 20 a. M.

21. I hereby certify that I attended the deceased from June 2, 1942, to June 5, 1942 that I last saw him alive on June 5, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary infarct, postcirc	
Due to: Thyrotoxicosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: As above	

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 [redacted] (M. D. or other)

Address BARNES HOSPITAL Date signed 6/6

(Licensed Embalmer's Statement on Reverse Side)

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. 387

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, fact should be so stated above.