

No. 2
-2-43
-17-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 320
Registrar's No. 389

FILED DEC 8 1943
Registration District No. 77

Primary Registration District No. 3161

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

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town New Bloomfield
(c) Name of hospital or institution: New Bloomfield, Missouri
(d) Length of stay: In hospital or institution No
In this community Six months

3. (a) PRINT FULL NAME Clara Lucinda Clough
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 11 years (Day) (Year)

7. Birth date of deceased 9 11 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 2 14 hr. min.

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

10. Usual occupation Nurse

11. Industry or business

12. Name Orlin Clough

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

14. Maiden name X

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

16. (a) Informant Latherine C. Hardy
(b) Address New Bloomfield, Mo.

17. (a) Cremation (b) Date thereof 11/27/1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State California (b) County Los Angeles 999
(c) City or town Los Angeles 4
(If outside city or town limits, write "RURAL") 0
(d) Street No. X
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 25
year 1943 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov 16 1943 to Nov 25 1943
that I last saw her alive on Nov 24 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 4 days
Duration

Due to

Due to

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations g 301
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 E. M. [unclear] (M. D. or other)
Address New Bloomfield Mo. Date signed 11/26/43

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 Ray A. Holt

Licensed Embalmer No. 2605

P. O. Address New Bloomfield, Missouri

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.