

FILED JAN 12 1944  
Registration District No. 4C

Primary Registration District No. 1000

Registrar's No. 1487

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town Saint Joseph,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri Methodist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days (Specify whether  
In this community 50 years, (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan //  
(c) City or town Saint Joseph, //  
(If outside city or town limits, write "RURAL")  
(d) Street No. 708 So 24<sup>th</sup> //  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Sarah Belle 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 Widowed

6. (b) Name of husband or wife Alfred Allen Clayton, 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 12th, 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 10 17 hr. \_\_\_\_\_ min.

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

10. Usual occupation Seamstress,

11. Industry or business Smith Bros. Mfg. Co.

MOTHER FATHER  
12. Name Unknown,  
13. Birthplace Unknown, (City, town, or county) (State or foreign country) 9  
14. Maiden name Unknown,  
15. Birthplace Unknown, (City, town, or county) (State or foreign country) 9

16. (a) Informant Mrs. Clarence Duncan

(b) Address Salinas, California,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/44 (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery,

18. (a) Signature of funeral director Rose Hervey

(b) Address 319 So. 10th. Street, Home

19. (a) 1-3-44 (Date received local registrar) (b) Rose Hervey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 29th.  
year 1943 hour 10:00 minute 30 p.M.

21. I hereby certify that I attended the deceased from Dec 28 1943 to Dec. 29 1943  
that I last saw him alive on Dec. 29 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia lobes Duration 10 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 106

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 Rose Hervey (M.D. or other)

Address St. Joseph, Mo. Date signed 1-3-44

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

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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 *Elmer Thomas*.....

Licensed Embalmer No. *2640*.....

P. O. Address *St. Joseph 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.**