S. No. 2
M—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 8 1944

Registration District No. 1 5 4

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7283

Primary Registration District No. 3023

Registrar's No. 43

1. PLACE OF DEATH

(a) County Henry

(b) City or town Clinton mo (If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 12 hours (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 42

(a) State Mo (b) County Henry

(c) City or town Clinton mo Rural (If outside city or town limits, write "RURAL")

(d) Street No. R R # 6 Clinton Twp (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country 0

3. (a) PRINT FULL NAME ANNA CLIFTON

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Fem

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Walter

6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased April (Month) 7 (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
69	10	6	hr. min.

9. Birthplace Scotland Co (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Home work

11. Industry or business

FATHER

12. Name Alexander Neil

13. Birthplace Lee Co (City, town, or county) Iowa (State or foreign country)

MOTHER

14. Maiden name Emma Harrigal

15. Birthplace Lee Co (City, town, or county) Iowa (State or foreign country)

16. (a) Informant Mrs John Batschelett

(b) Address Clinton mo RR # 6

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-44 (Month) (Day) (Year)

(c) Place: burial or cremation Englewood

18. (a) Signature of funeral director Cossdurf & Peck

(b) Address Clinton mo

19. (a) February 15 1944 (Date received local registrar) Georgia Ritchey (Registrar's signature)

1069

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 13, th. year 1944. hour 2:30. minute A. M.

21. I hereby certify that I attended the deceased from 3-3, 1939, to 2-13, 1944, that I last saw h 4 alive on 2-12- 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Valvular Heart Disease.	1
Right Sided.	✓
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)

While at work (e) Means of injury 1

23. Signature Joseph R Neil (M. D. or other) MD

Address Clinton, Mo. Date signed 2-15-44.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 2-44-196
Date Filed 3-4-44

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 J. E. Gonsalus

Licensed Embalmer No. 1891

P. O. Address Clinton 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.

S. No. 2B
M—5-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. AR y 1

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 43

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

1. PLACE OF DEATH:
(a) County Henry (b) City or town Clinton
(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 years, months or days) Life
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Anna Clifton
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 67 years

7. Birth date of deceased April (Month) (Day) (Year)

8. AGE: Years 69 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 7 day
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular heart disease Duration
Due to bright disease 1
Due to Hypertension. 32 y
Other conditions (Include pregnancy within 3 months of death)

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

23. Signature H B Neill MD (M. D. or other) MD
Address 3-10-44 Date signed
Clinton, Mo

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION FILED

7283