

No. 2  
-2-43  
-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11104

FILED APR 8 1944  
Registration District No. 18448

Primary Registration District No. 5523

State File No. \_\_\_\_\_

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Hickory

(b) City or town Rural Green Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickory

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

(d) Street No. Green Twp.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Sophia Clymore

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 3  
year 1944 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from Jan 24<sup>th</sup>, 1943 to Mar 3<sup>rd</sup>, 1944,  
that I last saw her alive on Sept 15<sup>th</sup>, 1943,  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, widow

6. (b) Name of husband or wife Medin Clymore 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
15 years

7. Birth date of deceased: Nov. 15 1851  
(Month) (Day) (Year)

Immediate cause of death Chronic Intestinal Pepsidic 3 yrs  
Duration

8. AGE: Years 92 Months 3 Days 18  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

9. Birthplace Hickory County Mo.  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 13/2

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Thomas Glanville

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

14. Maiden name HARRIETT KESER

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

PHYSICIAN

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Charley Clymore

(b) Address Preston Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof Mar 5 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? \_\_\_\_\_

(c) Place: burial or cremation Bower Chapel Cem.

18. (a) Signature of funeral director Vaughan + Keser

(b) Address Urban Mo.

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

19. (a) Mar 20 1944 Mary Glanville  
(Date received local registrar) (Registrar's signature)

23. Signature G. J. Myers (M. D. or other) \_\_\_\_\_  
Address MacKilgrew Mo. Date signed 3/3/44

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

RECEIVED

District Health

Off. of Health

District File Number

3-44-348

Date Filed

4-7-44

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.....

working under my personal supervision.

Registered Apprentice No.....

Signed.....

*Donald W. Lepin*

Licensed Embalmer No.....

5053

P. O. Address.....

Warsaw 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.