S. No. 2
—9-4-41
6-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 12 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

9386

State File No.

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 16

20
1
0

1. PLACE OF DEATH:

(a) County: Ceder
(b) City or town: El Dorado Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Adult Conservation Club 3
(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)
In this community: About 6 months

2. USUAL RESIDENCE OF DECEASED: 108

(a) State: Missouri (b) County: Vernon
(c) City or town: Schell City
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: NANCY HICKS CLOPTON

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Abner Clopton

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

7. Birth date of deceased: Nov. (Month) 6 (Day), 1869 (Year)

8. AGE: Years 75 Months 4 Days 14 If less than one day hr. min.

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

10. Usual occupation: Nurse

11. Industry or business

FATHER
12. Name: Shelby F. Hicks
13. Birthplace: Clinton (City, town, or county) Ky. 1 (State or foreign country)

MOTHER
14. Maiden name: Olevia Muse
15. Birthplace: Betis Co. (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant: B. W. Hicks
(b) Address: Schell City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 21 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn Cemetery

18. (a) Signature of funeral director: Kate Lewis & Son
(b) Address: Schell City, Mo.

19. (a) 3/20/45 (Date received local registrar) (b) L. I. Ownsway (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 20 year 1945 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from Mar 2, 1945, to Mar 20, 1945, that I last saw him alive on March 15, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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: L. T. Dunaway (M. D. or other)
Address: El Dorado Springs, Mo. Date signed: 3/20/45

1046

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED Order No. 337
D... 3-45
Date Filed 4-11-45

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 Marion M. Lewis

Licensed Embalmer No. 3084

P. O. Address Schell City, 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.