

FILED DEC 16 1946

Registration District No. 17

Primary Registration District No. 3012

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

Registrar's No. 157

1. PLACE OF DEATH:

(a) County Clay  
 (b) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Excelsior Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 hour  
(Specify whether  
 In this community 46 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24  
 (c) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 818 Linwood  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Josephine Clyce

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 Arthur Anderson Clyce 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 21 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
70 4 1 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Leonard Strahle 4

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

14. Maiden name Mary Studer

15. Birthplace Switzerland 5  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Clyce

(b) Address Excelsior Springs, Missouri

17. (a) Removal (b) Date thereof 11-25-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leavenworth, Kansas

18. (a) Signature of funeral director Claude Prichard

(b) Address Excelsior Springs, Missouri

19. (a) 11/26/46 (b) Caroline Butcher  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21  
 year 1946 hour 11 minute 50 P. M.

21. I hereby certify that I attended the deceased from 11-21  
 \_\_\_\_\_, 1946, to 11-21, 1946,  
 that I last saw her alive on 11-21, 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 6-Plu.

Due to Hypertension Stroke  
Arteriosclerosis

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations 83A  
 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)  
 (2) Means of injury \_\_\_\_\_

23. Signature E. Stohmann (M.D. or other) \_\_\_\_\_

Address Excelsior Springs, Mo. Date signed 11/22/46

1, 21

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 12-14-46

JAN 23 1959

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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 \_\_\_\_\_

Licensed Embalmer No. 4168

P. O. Address Evellion Springs

**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.**

Registration District No. 71

Primary Registration District No. 3012

1. PLACE OF DEATH

(a) County Clay  
(b) City or town Excelsior Springs  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME

Mary J. Clyde  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color w race \_\_\_\_\_  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased July 2 (Month) (Day) (Year)  
8. AGE: 70 Years Months Days If less than one Day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M. 21  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

36391