

S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32190**
Registrar's No. **2251**

Registration District No. **381**

Primary Registration District No. **4450**

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

1. PLACE OF DEATH:
(a) County **Ripley**
(b) City or town **Doniphan**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Williams Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Butler**
(c) City or town **rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Harviell Rt.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Myrtle Cleo Clayton**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **John Clayton** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **XXXXXX Dec 31, 1898**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 **7** **21** hr. min.

9. Birthplace **Clay Co. Tenn. /**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Keeper**

11. Industry or business _____

12. Name **James A. Brown**

13. Birthplace **Clay Co. Tenn. /**
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Brown**

15. Birthplace **Jackson Co. Tenn. /**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Clayton**

(b) Address **Harviell, Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 24/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fairdealing**

18. (a) Signature of funeral director **Minnie Gish**

(b) Address **Naylor, Mo.**

19. (a) **8-23-47** (b) *[Signature]*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **28**
year **1947** hour **2** minute **A** M.

21. I hereby certify that I attended the deceased from **August 16, 1947** to **Aug 22, 1947**
that I last saw him alive on **Aug 21, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary heart disease**
Due to **hypertension**
Due to _____

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

Major findings: Of operations **ATA**
Of autopsy _____

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)
(c) Means of injury _____

23. Signature *[Signature]* (M. D. or other) _____
Address **Doniphan** Date signed **8-27-47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 947527

Date Filed 9-25-47

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 Bryan C. McCord.....

Licensed Embalmer No. 4079.....

P. O. Address Wayton.....

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.