

S. No. 2
DM-5-43
v. 5-17-39
W I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 18 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33547
Registrar's No. 21

Registration District No. 370 Primary Registration District No. 6254

1. PLACE OF DEATH:
(a) County Wayne
(b) City or town rural Cedar Creek Twp.
(c) Name of hospital or institution;
near Silvia, Mo 1
(d) Length of stay: In hospital or institution days
In this community days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Wayne
(c) City or town rural
(d) Street No. _____
(e) Citizen of foreign country? no
If yes, name country _____

3. (a) PRINT FULL NAME Terry Jane Clubb
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 16 year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 12 1947

that I last saw h. _____ alive on _____ 19____ and that death occurred on the date and hour stated above.
Immediate cause of death Pneumonia Duration 2 days

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

Due to _____
Due to _____

9. Birthplace Silvia Mo
10. Usual occupation _____

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Dee Clubb
13. Birthplace Mo
14. Maiden name Louise Varak
15. Birthplace Mo

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 _____

16. (a) Informant John D Westmorland
(b) Address Silvia Mo
17. (a) Burial (b) Date thereof June 18/47
(c) Place: burial or cremation Mount Pisgah cem
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) Sept 11th 47 (b) Mabel Beasley

23. Signature J A Myers (M. D. or other) MD
Address Columbia Mo Date signed June 17

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

MOTHER FATHER

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

RECEIVED

District Health Officer No. 4

District File Number 947-1191

Date Filed 9-16-47

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.....

Licensed Embalmer No.....

P. O. Address.....

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.