

S. No. 2  
-12-45  
5-17-39  
K47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38784

State File No. ....

FILED NOV 17, 1947

Registration District No. 17

Primary Registration District No. 5630

Registrar's No. ....

1. PLACE OF DEATH:

(a) County WRIGHT LACLEDE

(b) City or town RUFOL  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3  
(If not in hospital or institution, write street number or location)

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

In this community 1 day  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County WRIGHT 114

(c) City or town HARTVILLE  
(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 JAMES EDWARD CLAXTON

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2  
year 1947 hour 12 minute 55 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on Nov. 2, 1947; and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JESSIE L CLAXTON

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

7. Birth date of deceased MAY 24 1959  
(Month) (Day) (Year)

Immediate cause of death Coronary occlusion Duration \_\_\_\_\_

Due to Cardiac decompensation ?

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

8. AGE: Years Months Days If less than one day

88 5 8 hr. \_\_\_\_\_ min.

9. Birthplace WRIGHT Co. Mo 6  
(City, town, or county) (State or foreign country)

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

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

Of autopsy 947

MOTHER FATHER

10. Usual occupation FARMER

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

12. Name HENDERSON CLAXTON

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

14. Maiden name SUSAN HARRISON

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

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

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

16. (a) Informant Jessie S. Clayton

(b) Address Hartville, Mo

17. (a) BURIAL (b) Date thereof 11-4-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation COLD WATER CEM

18. (a) Signature of funeral director Gene E Holden

(b) Address Hartville, Mo

19. (a) Nov. 8, 1947 (b) Dr. Frankenburg  
(Date received local registrar) (Registrar's signature)

23. Signature New Carrington (M. D. or other) M.D.  
Address Tellico, Mo Date signed 11/9/47

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

Received 11/11/47  
Lafayette County Health Unit  
File No. 11-47-194  
Date Filed 11/11/47

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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

*Gene E. Holdren*

Licensed Embalmer No.

*3865*

P. O. Address

*Hartsville, 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.