

FILED APR 29 1948

Registration District No. **238**

Primary Registration District No. **582 4345** Registrar's No. **283**

1. PLACE OF DEATH:

(a) County **NEW MADRID**

(b) City or town **Mathias**

(c) Name of hospital or institution: **1**

(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) **10 hrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**

(c) City or town **Mathias Mo**

(d) Street No. **Rt 1** (If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME **ROBERT CLAYTON**

3. (b) If veteran, name war

3. (c) Social Security No. **1**

4. Sex **M O**

5. Color or race **X**

6. (a) Single, widowed, married, divorced **S U**

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day **10 hr** min.

9. Birthplace **Mathias mo** (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Robert Ray Clayton**

13. Birthplace **Mathias mo** (City, town, or county) (State or foreign country)

14. Maiden name **Rose Co**

15. Birthplace **Mathias mo** (City, town, or county) (State or foreign country)

16. (a) Informant **E. B. Clayton**

(b) Address **Rt 1 Mathias mo**

17. (a) **3-10-48** (b) Date there (Month) (Day) (Year)

(c) Place: burial or cremation **Mathias mo**

18. (a) Signature of funeral director **E. B. Clayton**

(b) Address **Mathias mo**

19. (a) **4-20-48** (b) **Helene Lamberson** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **9** year **1948** hour **2 P.M.** minute **30** M.

21. I hereby certify that I attended the deceased from **19** to **19** that I last saw **alive on 3-9-48** and that death occurred on the date and hour stated above.

Immediate cause of death **Premature 7 months** Duration

Due to **Premature**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **5-1**

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 **E. J. Martice** (M. D. or other)

Address **Rt 1 Mathias mo** Date signed **3-10-48**

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

RECEIVED

District Health Office No. 2

District File Number 48-53

Date Filed 4-22-48

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.....

Not Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed John A. [Signature]

Licensed Embalmer No. 2951

P. O. Address Superior Ave

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.