

THE DIVISION OF HEALTH OF MISSOURI
FILED OCT 18 1949 STANDARD CERTIFICATE OF DEATH

34269

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 171 PRIMARY REG. DIST. NO. 5639 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>Hazardette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hazardette</u> <u>54</u>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Rural - Washington - Twp. wife!</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Washington - Twp.</u> <u>6</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>2 1/2 mi. - S.E. Odessa - Mo.</u>		<u>2 1/2 mi. S.E. Odessa, Mo.</u> <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u>	b. (Middle) <u>Vernal</u>	c. (Last) <u>Clonts.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 10 1949</u>
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5. SEX <u>0</u> <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married.</u>	8. DATE OF BIRTH <u>Febr. 17 - 1922</u>	9. AGE (In years last birthday) <u>27</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (What kind of work done during most of working life, even if retired) <u>Shipping Clerk.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Factory</u>	11. BIRTHPLACE (State or foreign country) <u>Hazardette - Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robt. Clonts.</u>	13b. MOTHER'S MAIDEN NAME <u>Lora Clonts.</u>	14. NAME OF HUSBAND OR WIFE <u>Kathleen Clonts.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>489-24-023</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Kathleen Clonts - Odessa Mo.</u>	ADDRESS <u>Odessa Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocarditis</u>		<u>Indef.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Asthma, Bronchial</u> DUE TO (c) _____		<u>8 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostate mellitus</u>		<u>24 1/2</u>	<u>8 yrs</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Sept 10, 1949, to Sept 11, 1949, that I last saw the deceased alive on Sept 11, 1949, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>E. F. Slaght</u>	23b. ADDRESS <u>Odessa Mo.</u>	23c. DATE SIGNED <u>9/12/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial.</u>	24b. DATE <u>Sept 13 - 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Odessa - Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Oct 13 '49</u>	REGISTRAR'S SIGNATURE <u>Leta Drummond</u>	153	25. FUNERAL DIRECTOR'S SIGNATURE <u>Blaise & Sons</u>	ADDRESS <u>Odessa Mo.</u>
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WRITE PLAINLY--USING UNFAADING BLACK INK--MAKE A PERMANENT RECORD

OCT 14

RECEIVED

District Health Officer No. 3,

District File Number _____

Date Filed 10-15-49

OCT 18 1949

APR 20 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Clyde R. B. ...

Licensed Embalmer No. 2945

Signed _____
Student Embalmer

P. O. Address Adrian 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.