

FILED MAY 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12570**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **448**

03096

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Aurora	
c. LENGTH OF STAY (In this place) 10 days		d. STREET ADDRESS (If rural, give location) 116 East Church	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) L c. (Last) Clopton			4. DATE OF DEATH (Month) (Day) (Year) May 10 1950
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 29, 1881
9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY High School	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Daniel E Clopton		13b. MOTHER'S MAIDEN NAME Mary E Brown	14. NAME OF HUSBAND OR WIFE Bessie Clopton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Thomas Clopton, Springfield, Missouri
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of prostate INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uremia	
19a. DATE OF OPERATION 5-6-50		19b. MAJOR FINDINGS OF OPERATION Carcinoma of prostate gland	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 5-1 , 19 50 , to 5-10 , 19 50 , that I last saw the deceased alive on 5-10 , 19 50 , and that death occurred at 5:00P m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Robert W. Maher, M.D.		23b. ADDRESS Med Arts Bldg	23c. DATE SIGNED 10 May 50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/14/50	24c. NAME OF CEMETERY OR CREMATORY Maple Park	24d. LOCATION (City, town, or county) (State) Aurora, Mo
DATE REC'D BY LOCAL REG. 5-11-50	REGISTRAR'S SIGNATURE W.F. Handley	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William Wood Aurora, Mo	

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.

Student
Student Embalmer

Signed William Wood.....

Licensed Embalmer No. 4539.....

P. O. Address Aurora, 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.