S. No. 300
v. 10.48

FILED FEB 15 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43971

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 144 PRIMARY REG. DIST. NO. 4234 Registrar's No. 5

1. PLACE OF DEATH
a. COUNTY Iron 0470
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ironton
c. LENGTH OF STAY (in this place) 2 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 320 Knob St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Iron 0470
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ironton
d. STREET ADDRESS (If rural, give location) 320 Knob St.

3. NAME OF DECEASED (Type or Print) a. (First) Josephine b. (Middle) Clinkenbeard c. (Last)

4. DATE OF DEATH (Month) Dec. (Day) 30 (Year) 1951

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH March 27 1859
9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR Months 9 Days 3 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Robert Stanford
13b. MOTHER'S MAIDEN NAME Francis Price
14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT'S SIGNATURE OR NAME Bessie Karinger ADDRESS Ironton Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 331 X
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 27, 1951, *to* Dec 30, 1951, *that I last saw the deceased alive on* Dec 30, 1951, *and that death occurred at* 1:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE J. H. McIntosh (Degree or title) M.D.
23b. ADDRESS 209 N. Main St. Ironton Mo.
23c. DATE SIGNED Jan 1952

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1-2-52
24c. NAME OF CEMETERY OR CREMATORY Patoci Masonic
24d. LOCATION (City, town, or county) (State) Patoci Mo.

DATE REC'D BY LOCAL REG. Feb. 13, 1952
REGISTRAR'S SIGNATURE Mrs Avis Jones 128-1
25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Luther Sparks ADDRESS Patoci Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

1951

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 _____

_____, working under my personal supervision.

Student Embalmer No. _____

Signed Murphy L. Lewis

Signed _____
Student Embalmer

Licensed Embalmer No. 4236

P. O. Address Flat River 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.