

FILED FEB 1 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 620

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>73</u> | | PRIMARY REG. DIST. NO. <u>5291</u> | | Registrar's No. <u>6</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>CLAY</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>BUCHANAN</u> | | | |
| b. CITY OR TOWN <u>LIBERTY P.B.</u> | | c. LENGTH OF STAY (in this place) <u>4 yrs</u> | | c. CITY OR TOWN <u>ST. JOSEPH</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Foot Home</u> | | | | e. STREET ADDRESS (If rural, give location) <u>unknown</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>MARGARET</u> b. (Middle) <u>CATHERINE</u> c. (Last) <u>CLAPP</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 21 1954</u> | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> | | 8. DATE OF BIRTH <u>SEPT. 14, 1865</u> | |
| 9. AGE (In years last birthday) <u>88</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>MONMOUTH, ILL</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>MONMOUTH, ILL</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13a. FATHER'S NAME <u>DAVID G. GLENN</u> | | | 13b. MOTHER'S MAIDEN NAME <u>NANCY AGNESS REED</u> | | | 14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Foot Home</u> ADDRESS <u>Liberty, Mo</u> | | | |
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Artery disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>General Arteriosclerosis</u> 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 <u>4201</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.) | | 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 <u>Nov</u> , 19 <u>49</u> , to _____, 19____, that I last saw the deceased alive on <u>Jan 19, 1954</u> , and that death occurred at <u>8 AM.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>W. J. Sadson MD</u> (Degree or title) | | | | 23b. ADDRESS <u>Liberty Mo</u> | | 23c. DATE SIGNED <u>JAN 21 1954</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 24b. DATE <u>1/21/54</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo</u> | |
| DATE REC'D BY LOCAL REG <u>Jan 23 1954</u> | | REGISTRAR'S SIGNATURE <u>Mabel Graham</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Neaton-Bowman-St. Joseph, Mo</u> | | ADDRESS | |

(Licensed Embalmer's Statement on Reverse Side)

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

Mrs. Wilkin
W. Rowson
17 W. 5th
So side

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.....
Signature of Student Embalmer

Signed.....
Eugene Wood

Licensed Embalmer No.....
38

P. O. Address.....
319 So 10th St

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.