

Health, Welfare
Public Service

FILED JUL 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25162

STATE FILE NUMBER

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 82

300
-57
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|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Johnson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Center View</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Warrensburg Med. Cln.</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>510</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>George C. Clavin</u> | | | 4. DATE OF DEATH Month Day Year <u>July 13 1957</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 28, 1888</u> |
| 9. AGE (In years last birthday) <u>69</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u> | 11. BIRTHPLACE (City and state or country) <u>Brunswick, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13a. FATHER'S NAME <u>Tom Clavin,</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Mary Guest,</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mrs Doris Clavin,</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>485-34-8145</u> | |
| 17. INFORMANT <u>Mrs. Glen Winfrey, (Dau.)</u> | | Address <u>4200 Monroe, Kansas City, Mo</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronaria Pectoria</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased from <u>Sept 1951</u> to <u>13 July 1957</u> and last saw him alive on <u>13 July 1957</u> Death occurred at <u>5:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Deed Maxson M.D.</u> (Degree or title) | | 22b. ADDRESS <u>Warrensburg Mo</u> | |
| 22c. DATE SIGNED <u>14 July 57</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>July 16, 1957</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills,</u> | | 23d. LOCATION (City, town, or county) (State) <u>Blue Ridge & Gregory, K.C. Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>FLORAL HILLS MEM. CHAPELS, KANS. CITY, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>July 4 1957</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Savannah C. C. C. C.</u> | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Everett L. Sell*

Licensed Embalmer No. *4861*

P. O. Address *Danson Cal*

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.