

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047126

FILED VS DEC 23 1960

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 295 STATE FILE NUMBER

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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Randolph</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Moberly</u>                            |  | Length of stay in lb<br><u>12 years</u>   | c. CITY OR TOWN <u>Moberly</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>1027 North Morley Street</u> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>1027 North Morley St.</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Stella</u> Middle <u>Clayburg</u> Last <u>Clayburg</u>          |                                  |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>13</u> Year <u>1960</u>    |   |   |
| 5. SEX<br><u>female</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6-18-1878</u>  | 9. AGE (last birthday)<br><u>82</u>                       | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>home</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Chariton Co., Missouri</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>United States</u>       |   |
| 13a. FATHER'S NAME<br><u>Joseph Krager</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Iona Wasson</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>William H. Clayburg</u> |   |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u> | 16. SOCIAL SECURITY NO.<br><u>none</u> | 17. INFORMANT<br><u>Mrs. Ray Porter: Marceline, Missouri</u> | Address |
|---|--|--|---------|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br><u>Sudden</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>  </u><br>DUE TO (c) <u>  </u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u> |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |  |
|---|--|--|--|

|   |   |  |  |
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| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>                               | Month, Day, Year <u>  </u>  |  |  |

|   |  |                              |        |       |
|---|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Jan 1-55 to Dec 13-60 and last saw her mm alive on Dec 13-60  
-Death occurred at 10:30 p on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                   |                                     |
|--|-----------------------------------|-------------------------------------|
| 22a. SIGNATURE<br><u>J. H. ...</u> (Degree or title) | 22b. ADDRESS<br><u>Moberly Mo</u> | 22c. DATE SIGNED<br><u>12-16-60</u> |
|--|-----------------------------------|-------------------------------------|

|  |                                |  |   |
|--|--------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u> | 23b. DATE<br><u>12-16-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fairview Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>near Bynumville, Missouri</u> |
|--|--------------------------------|--|---|

|   |   |   |
|---|---|---|
| 24. FUNERAL DIRECTOR<br><u>Tom B Patton</u> ADDRESS <u>Huntsville</u> | 25. DATE RECD. BY LOCAL REG.<br><u>12-16-60</u> | 26. REGISTRAR'S SIGNATURE<br><u>Reaber Lowe</u> |
|---|---|---|

no (Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Tom B Patton*

Licensed Embalmer No. 3919

P. O. Address Huntsville

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.