

FILED OCT 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29305

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>112</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1035</u>			
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>					
b. CITY (If outside corporate limits write RURAL and give OR TOWN <u>St Joseph</u> () township)		c. LENGTH OF STAY (in this place) <u>3. hours</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St Joseph</u>		11			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Rout 4 McCarthy Road</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Xenia</u> c. (Last) <u>Clayton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 24 1949</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>		8. DATE OF BIRTH <u>Mar 1 1893</u>			
9. AGE (In years last birthday) <u>56</u>		10. MONTHS <u>6</u>		11. DAYS <u>23</u>		12. IF UNDER 1 YEAR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>1</u>		11. BIRTHPLACE (State or foreign country) <u>Hentry County MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Jasander Gunning</u>			13b. MOTHER'S MAIDEN NAME <u>Nora Zick</u>			14. NAME OF HUSBAND OR WIFE <u>Earnest Clayton</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>--</u>		17. INFORMANT'S SIGNATURE OR NAME <u>E. S. Clayton</u> ADDRESS <u>St Joseph R. 4</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arterio Sclerosis</u>							<u>3 yrs</u>		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES							
		DUE TO (b) <u>cerebral hemorrhage</u>					<u>4 hrs</u>		
		DUE TO (c) <u>cerebral hemorrhage</u>					<u>331X</u>		
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						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)		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>Sept-24, 1949</u> , to <u>Sept-24, 1949</u> , that I last saw the deceased alive on <u>Sept-24, 1949</u> , and that death occurred at <u>11 P.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>G. J. Kimball</u> (Degree or title) <u>MD</u>			23b. ADDRESS <u>St Joseph MO P.R. 4</u>			23c. DATE SIGNED <u>Sept-26-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 26 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Foster Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>New Hampton MO</u>			
DATE REC'D BY LOCAL REG. <u>Sept 26, 1949</u>		REGISTRAR'S SIGNATURE <u>B. C. Jenkins</u> 382		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Noble</u> ADDRESS <u>New Hampton Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

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7

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 me

Student Embalmer No. _____

working under my personal supervision.

Signed W. G. Noble

Signed _____
Student Embalmer

Licensed Embalmer No. 2904

P. O. Address New Hampton 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.