

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

31744

7

1. PLACE OF DEATH

County *Marion*
Township *South fork*
City *William W. Clement*

Registration District No. *586*
Primary Registration District No. *5784*

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

William W. Clement

(a) Residence, No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF *10 25 1861 Effie Clement*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS *74* MONTHS *9* DAYS *24* If LESS than 1 day, _____ hrs. or, _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Farmer*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

13. NAME *A J Clement*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

15. MAIDEN NAME *Sarah Witherson*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT (NAME) *(Wife) Mrs Clement*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Santa Fe, Mo, Aug 3 1936*

19. UNDERTAKER (NAME) *Snyder & Hanger*

20. FILED *Aug 10 1936 Effie B. Orake*

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 2 1936*

22. I HEREBY CERTIFY, That I attended deceased from *as a witness after death* 19____, to _____, 19____. I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Angina pectoris *rubrum*
940

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify _____
(Signed) *John Brown* M. D.
(Address) *Princeton, Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Handwritten notes and scribbles, including the word "EX" and other illegible markings.