

No. 2
5-43
5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 30 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Hyde
State File No. **28594**

Registration District No. **236** Primary Registration District No. **6137** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Shannon**
(b) City or town **1 1/2 mi E of Winona Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **17 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Shannon 101**
(c) City or town **rural** (If outside city or town limits, write "RURAL")
(d) Street No. **3 Mi E of Winona, Mo.** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Norman Larry Clemons**
3. (b) If veteran, name war **no** 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 22 1931**
(Month) (Day) (Year)

8. AGE: Years **17** Months **4** Days **10** If less than one day hr. _____ min. _____

9. Birthplace **Eminence Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Student**

11. Industry or business _____
12. Name **Unknown**
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **Inez Clemons**
15. Birthplace **Winona Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **J H Clemons**
(b) Address **Winona, Mo.**
17. (a) **Burial** (b) Date thereof **8-3-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **in cemetery**
18. (a) Signature of funeral director **Duncan Funeral Home**
(b) Address **Mountain view, Mo.**
19. (a) **8-21-48** (b) **Michael R. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **1**
year **1948** hour **11** minute **50 a M.**
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Auto. mobile accident**
Keen & instantly
Due to **Cerebral Head**
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) **101**
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway near Winona Mo
While at work? (Specify type of place) (e) Means of injury **Car**
23. Signature **Frank Hyde** (M. D. or other) **Carver**
Address **Eminence Mo.** Date signed **8-10-48**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

RECEIVED 8-24-48
District Health Officer No. 5,
8485-32
District File Number 8-24-48
Date Filed

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Joe B. Ruman
Licensed Embalmer No. 4325
P. O. Address Mt. View, 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.