APR 15 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11890

Registration District No. 775 Primary Registration District No. 6020-a Registrar's No. 19

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

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonne Terre
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One Day (Specify whether
In this community 63 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Francois
(c) City or town Leadwood
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME BERT JAMES OKAY
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Ann Okay
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased May (Month) 2 (Day) 1877 (Year)

8. AGE: Years 63 Months 5 Days 24 If less than one day hr. min.

9. Birthplace Leadwood (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name Robert J. Clay
13. Birthplace (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Nerchnice Backenridge
15. Birthplace (City, town, or county) Mo (State or foreign country)

16. (a) Informant Ann Okay
(b) Address Leadwood Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28 1941 (Month) (Day) (Year)
(c) Place: burial or cremation Farmington Public Vault
18. (a) Signature of funeral director J. A. Boyce & Son
(b) Address Leadwood Mo
19. (a) Feb 28 1941 (Date received local registrar) (b) M. W. Hawkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26
year 1941 hour 5 minute 1 M.

21. I hereby certify that I attended the deceased from 2-25-, 1941, to 2-26-, 1941;
that I last saw him alive on 2-25-, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hem-	
orrhage.	2 da.
Due to Hypertension	3
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. M. Roebbes, (M. D. or other) M.D.
Address Bonne Terre, Mo. Date signed 2-28-41

(Licensed Embalmer's Statement on Reverse Side)

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 Bert L Boyer

Licensed Embalmer No. 3446

P. O. Address Lakewood Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2
1-4-41
-17-39
X26390

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

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STANDARD CERTIFICATE OF DEATH

State File No. 11890

Registration District No. 775 — Primary Registration District No. 6020A — Registrar's No.

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME Bert James Clay
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
63	5	24	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation Retired - farmer
11. Industry or business Lead Mining

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) March 8 1941 (Date received local registrar) (b) W. W. Hawkins (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26
year 1941 hour minute 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	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. M. Robbins (M. D. or other)
Address Bonne Terre Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

11890

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.