

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

National Office of Vital Statistics
FILED JUN 16 1948

Registration District No. 378

Primary Registration District No. 6075

Registrar's No. 176

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Missouri State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 2 mos. 26 das.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison
(c) City or town Fredericktown
(If outside city or town limits, write "RURAL")
(d) Street No. Unknown
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JAMES FRANKLIN CLUBB

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nellie Bly
6. (c) Age of husband or wife if alive Approx. 1887 years (Day) (Year)

8. AGE: Years 61 Months Days If less than one day
.....hr.min.

9. Birthplace Wayne County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Carpentry and common labor.

11. Industry or business

12. Name Lawson Clubb
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Nanny Mansfield
15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 5-14-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hospital Cem., Farmington, Mo.

18. (a) Signature of funeral director Covean Funeral Home
(b) Address Farmington, Missouri

19. (a) 6-7-48 (b) Ether Redloff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13
year 1948 hour 2 minute 35 P. M.

21. I hereby certify that I attended the deceased from May 6, 1948 19... to May 13, 1948 19...
that I last saw him alive on May 13, 1948 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Psychosis with cerebral arteriosclerosis

Major findings: Of operations

Of autopsy No 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)

(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 John J. [Signature] or other

Address State Hwy #4, Farmington Date signed 6/23/48

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

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

MOTHER FATHER

62
1
1

289

RECEIVED

District Health Officer No. 4

District File Number 648-763

Date Filed 6-15-48

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.

not embalmed

Signed..... *C. Cozma*

Licensed Embalmer No. 4084

P. O. Address Farmington

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.