

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26106

State File No. \_\_\_\_\_

Registration District No. 743 Primary Registration District No. 6237 Registrar's No. \_\_\_\_\_

9  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: 2  
(a) County Ray  
(b) City or town Rural Excelsior Springs  
(c) Name of hospital or institution: 1 mi East of Excelsior Springs  
(If not in hospital or institution, write street number of location)  
(d) Length of stay: In hospital or institution at home (Specify whether years, months or days) 76 yrs

3. (a) PRINT FULL NAME ANNIE LEE CLEVINGER  
3. (b) If veteran, name war NO 3. (c) Social Security No. 710

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Jasper Clevinger 6. (c) Age of husband or wife if alive Dead years  
7. Birth date of deceased July 21, 1864 (Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 21 If less than one day x hr. x min.

9. Birthplace Clay Co MO (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business 6

12. Name John Trimble  
13. Birthplace 714 (City, town, or county) (State or foreign country)

14. Maiden name Patricia Jane  
15. Birthplace Clay Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Paul Clevinger  
(b) Address Excelsior Springs Mo

17. (a) Buried (b) Date thereof 7/14/40 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Graveside

18. (a) Signature of funeral director W. B. Baird  
(b) Address Excelsior Springs

19. (a) 7/17/40 (b) W. B. Baird (Date received local registrar) (Registrar's signature)

20. USUAL RESIDENCE OF DECEASED: Ray  
(a) State MO (b) County Clay  
(c) City or town Excelsior Springs Rural (If outside city or town limits, write "RURAL")  
(d) Street No. Rural 1 mi East of Spg (If rural, give location)  
(e) If foreign born, how long in U. S. A. ✓ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 1940 hour 6 minute 30 P. M.  
21. I hereby certify that I attended the deceased from Dec 15 1937 to July 12 1940 that I last saw h at alive on July 12 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Gas embolus thrombosis Coronary thrombosis  
Due to Cardiopathy  
Due to 44A  
Other conditions none (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: none  
Of operations none  
Of autopsy no  
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? 057  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. B. Baird (M. D. or other) !  
Address Excelsior Springs Date signed 7-13-40

RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 8-16-40

**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 *Sw. Adkensmith*

Licensed Embalmer No. 3597

P. O. Address Excelsior Springs, 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, above space should be left blank.