FEB 23 1928

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

2136

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

1. PLACE OF DEATH
County: Polk
Township: Campbell
City: (No. ..... St. ..... Ward)
Registration District No. 701
Primary Registration District No. 5935
File No. .....
Registered No. 6

2. FULL NAME: Orba Clark
(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: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Bob Clark
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Apr. 3-1886
7. AGE: Years 41, Months 9, Days 23; If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife 34 55
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): mo.

PARENTS
10. NAME OF FATHER: D H. Campbell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): mo.
12. MAIDEN NAME OF MOTHER: Nella Akins
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): mo.

14. INFORMANT: Ida Joseph
(Address) Humansville mo.

15. FILED Jan 29, 1928 J F Robert REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 26 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1927, to Jan 26, 1928, that I last saw her alive on Nov 20, 1927, and that death occurred, on the date stated above, at 7 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brain Tumor
(Inertia)
..... (duration) ..... yrs. 18 mos. ..... ds.

CONTRIBUTORY (SECONDARY): 38
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Wasserman
(Signed) C N Hahn, M.D
, 19 (Address) Humansville mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Lindley Prairie
DATE OF BURIAL: 1-29 1928
20. UNDERTAKER: Ida Joseph
ADDRESS: Humansville 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.

...ENTIRELY UNFADING INK—THIS IS A PERMANENT RECORD

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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