

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

Do not use this space.

26516

1. PLACE OF DEATH

City Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City K. C. Mo. (No. Menorah Hospital St. 3257 Ward 325)

2. FULL NAME Joseph M. Clarkson

(a) Residence, No. 624 W. 61 St. _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan. 7, 1918</u>				
7. AGE	YEARS <u>15</u>	MONTHS <u>7</u>	DAYS <u>7</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>School</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____			
	10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. C. Mo.

13. NAME James A. Clarkson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Echel Martin

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) James A. Clarkson

18. BURIAL, CREMATION, OR REMOVAL Street Hill DATE 8-15-1933

19. UNDERTAKER (ADDRESS) Funeral Home

20. FILED 8-15-1933 M. M. Crow Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-14-1933

22. HEREBY CERTIFY, That I attended deceased from Aug. 6, 1933, to Aug. 14, 1933
 I last saw him alive on Aug. 13, 1933. Death is said to have occurred on the date stated above, at 7:4 m.

The principal cause of death and related causes of importance were as follows:

Paternal Sinus Thrombosis
metastatic pneumonia

Other contributory causes of importance:
82 B
187 K

Name of operation Yes Date of Aug 6

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Alban Sopher, M. D.

(Address) 1405 Bryant Bldg

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

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.

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