

12670 MAR 9 1939

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

6796
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 407
(b) Township Castorville Primary Registration District No. 4211 Registered No. _____
(c) City Castorville (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mo. da. (f) How long in U.S., if of foreign birth? yrs. mo. da.

2. PRINT FULL NAME

James J. Clark
(a) Residence, No. 317 N. Fountain St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 4 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 0 13

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Barber
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) Monticello Arkansas

13. NAME John B. Clark

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

15. MAIDEN NAME Frances E. McVane

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

17. INFORMANT (ADDRESS) Mrs. Frances Clark Castorville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mount Hope Church Feb 18 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wells City Undert Co. Wells City, Mo.

20. FILED 2/18 1939 J. W. Clark Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 17 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 12 1939, to Feb 17 1939.
I last saw him alive on Feb 17 11:15, 19..... Death is said to have occurred on the date stated above, at..... m.
The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia
Date of onset 10/8

Other contributory causes of importance:
Pneumonia

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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) W. H. G. M. 2 M. D.
369 (Address) Wells City, 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.

RECEIVED

District Health Officer No. 6

District File Number 6-39-488

Date Filed MAR 6 1939

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 myself

....., Registered Apprentice No.
working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 3922

P. O. Address Webb City, 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.