

REC'D MAY 22 1939

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

15845  
Do not use this space.

1. PLACE OF DEATH

(a) County Walker Registration District No. 703  
(b) Township Johnson Primary Registration District No. 4424  
(c) City Humansville (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. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 462 Josiah T. Clark St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 28 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
80 9 7

OCCUPATION 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. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Mo (STATE OR COUNTRY) 0

FATHER 13. NAME James Clark

14. BIRTHPLACE (CITY OR TOWN) Tenn (STATE OR COUNTRY) 1

MOTHER 15. MAIDEN NAME Melandy Clark

16. BIRTHPLACE (CITY OR TOWN) Tenn (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT Susie Clark (ADDRESS) Humansville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Walker Mo DATE May 8 1939

19. FUNERAL DIRECTOR (NAME) Joseph T. Finestone (ADDRESS) Humansville Mo

20. FILED May 8 1939 Chas M. Rich Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 7 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 1938, to May 7 1939

I last saw him alive on May 7 1939. Death is said to have occurred on the date stated above, at 2:30 a.m.

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

Cerebral Hemorrhage Date of onset \_\_\_\_\_

Other contributory causes of importance: JFW

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) Furston O. Sterrett, M. D.

(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.

34  
4  
0

RECEIVED  
District Health Officer No. 7,  
District File Number 7-39-79  
Date Filed 5-11-39

**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 *Ralph A. Joseph*  
Licensed Embalmer No. *3149*  
P. O. Address *Hannsville,*

**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.**