

25 JUL 18 1939

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

21862
Do not use this space.

1. PLACE OF DEATH *Clark* ²
 (a) County *Lincoln* Registration District No. *190*
 (b) Township *Lincoln* Primary Registration District No. *5264* Registered No. *38*
 (c) City (d) Street No.
 (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.
 467 *William Wesley Clark*
 2. PRINT FULL NAME
 (a) Residence, No. (Usual place of abode, if no street address, write county or city) (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) *widowed*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Jane Maloy Clark*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 7, 1851*
 7. AGE YEARS *88* MONTHS *1* DAYS *11* If LESS than day, hrs or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired*
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 18, 1939*
 22. HEREBY CERTIFY, that I attended deceased from *June 18, 1939* to *June 18, 1939*
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at *9:00 a.m.*
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage Date of onset *June 18*
apoplexy
 Other contributory causes of importance: *Old age*
 Name of operation..... Date of.....
 What test confirmed diagnosis? *Clinical* 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? *no*
 If so, specify.....
 (Signed) *Dean Swift D.D., M.D.*
 174 (Address) *Kahokas, Mo.*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Lee County, Iowa*
 FATHER 13. NAME *Garrett C. Clark*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*
 MOTHER 15. MAIDEN NAME *Nancy (unknown)*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Not Known*
 17. INFORMANT *Mrs. Chas. Maloy*
 (ADDRESS) *Wayland, Mo.*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Sand Cemetery* DATE *June 20, 1939*
 19. FUNERAL DIRECTOR (NAME) *H. P. Kircher*
 (ADDRESS) *Wayland, Mo.*
 20. FILED *720* *1939* *J. B. Bridges*
 Local Registrar.

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. 10

District File Number 7-39-1248

Date Filed JUL 12 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, _____

S. P. Kircher, _____, or by _____

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

Signed _____

S. P. Kircher

Licensed Embalmer No. 2611

P. O. Address Wayland, 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.