

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.

AUG 9 1939

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

25003

Do not use this space.

1. PLACE OF DEATH

(a) County Boone Registration District No. 73
(b) Township Columbia Primary Registration District No. 5112 Registered No. 152
(c) City Columbia (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

462 LUCY MERRIL CLARK
(a) Residence, No. _____ 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>James B. Clark</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 17, 1870</u>		
7. AGE	YEARS <u>68</u>	MONTHS <u>11</u>
	DAYS <u>3</u>	IF LESS THAN 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>House wife</u>	
	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	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>	
	13. NAME <u>Willard Tucker</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>	
	15. MAIDEN NAME <u>Louisa Graves</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>	
17. INFORMANT (ADDRESS) <u>James B. Clark</u> <u>Boone County, Mo.</u>		
18. BIRTH, CREATION, OR REMOVAL PLACE, OR REMOVAL DATE <u>Helbyville, Kentucky</u> <u>7-24-39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. O. Fischer</u> <u>Columbia, Mo.</u>		
20. FILED <u>7/21</u> 19 <u>39</u> <u>Allie Selby</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 20 1939

22. I HEREBY CERTIFY, That I attended deceased from July 12th 1939, to July 15th 1939
I last saw him alive on July 14th 1939 Death is said to have occurred on the date stated above, at 4:30 p.m.
The principal cause of death and related causes of importance were as follows:
Myocardial infarction with compensatory hypertrophy
Date of onset to not know

Other contributory causes of importance:
Calcium metabolism July 29

Name of operation _____ Date of _____
What test confirmed diagnosis urine analysis 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) W. O. Fischer M. D.
7/21 (Address) Columbia Mo.

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.....
Charles King....., Registered Apprentice No. 161
working under my personal supervision.

Signed *M. N. Philandis*.....
Licensed Embalmer No. 2893
P. O. Address Calumissia

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.