

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

4106

State File No. 3

Registration District No. 877 Primary Registration District No. 4330 Registrar's No.

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Schell City MO
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days 111

3. (a) PRINT FULL NAME William Thomas Clark
(b) If veteran, _____ (c) Social Security No. _____
name war _____

4. Sex Male 5. Color or race White 8. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Fannie Clark 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Nov 30 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months 1 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business Farming

12. Name Thomas Clark

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Mary Weaver

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Maggie Walker

(b) Address Schell City MO

17. (a) Burial (b) Date thereof Jan 24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cremation

18. (a) Signature of funeral director Lyle Lewis & Son
(b) Address Schell City MO 5017

19. (a) Jan 24-40 (b) Pearle Razick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Vernon
(c) City or town Schell City MO
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23
year 1940 hour 8 AM minute 30 M.

21. I hereby certify that I attended the deceased from Jan 13 1940 to Jan 22 1940
that I last saw him alive on Jan 22 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Osteosarcoma of Temporal Bone of Skull
Due to Superior Maxillary Bone
Right Side Neck
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: _____

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place) (e) Means of injury _____

23. Signature J. P. Colson (M. D. or other) _____

Address Schell City MO Date signed 1-23-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

52

RECEIVED
District Health Officer No. 7,
District File Number 2-40-192
Date Filed 2-12-40

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 _____
Licensed Embalmer No. _____
P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 4106

Registration District No. 877

Primary Registration District No. 4530

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Shell City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Wm Thomas Clark

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 79 Months 1 Days 23 If less than one day _____ hr _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan 2 1940 (Date received local registrar) JRC Colson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

19. MEDICAL CERTIFICATION
20. DATE OF DEATH Month Jan day 1 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death
Cites Sarcoma of Temporal bone of Skull + Superior
Due to maxillary bone 2 sides of skull
Due to En Petrosa partia Temporal Bone primary

Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury _____
23. Signature J.R. Colson (M. D. or other) _____
Address Shell City Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

