

S. No. 2  
11-10-39  
5-17-39  
I X21492

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

Registration District No. 399 Primary Registration District No. 1002 State File No. \_\_\_\_\_ Registrar's No. 2365

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 623 Noast  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 6.9 years  
years, months or days)

3. (a) PRINT FULL NAME Robert W. Clarke  
(b) If veteran, name war none  
(c) Social Security No. none

4. Sex Male 5. Color or race Wh  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased: Jan 12 1870  
(Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 24 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

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

10. Usual occupation News paper work

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Harry C Clarke  
13. Birthplace Mars  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary S Sheppard  
15. Birthplace Pa  
(City, town, or county) (State or foreign country)

16. (a) Informant James P Bird

(b) Address 4022 - Benton

17. (a) Burial (b) Date thereof June 10 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem

18. (a) Signature of funeral director Wm. C R Foster  
(b) Address 918 Brooklyn

19. (a) June 10, 1940 (b) M. M. Clarke  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City mo  
(If outside city or town limits write "RURAL")  
(d) Street No. 623 Noast  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 6 day 6 - 40  
year \_\_\_\_\_ hour \_\_\_\_\_ minute 6 A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Reflux of the Gall Bladder  
Chronic Cholecystitis & Stones

Other conditions (Include pregnancy within 3 months of death) 126

Major findings: Of operations \_\_\_\_\_  
Of autopsy above

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) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Russell W. Foster (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

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**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

*Denzil C. Browning*

Licensed Embalmer No. *2724*

P. O. Address *H. C. No.*

**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.**