

Registration District No. **318**

Primary Registration District No. **2801**

Registrar's No. **856**

FILED NOV 12 1940

1. PLACE OF DEATH:

(a) County Brewer
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 Days
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Ollie M Clark
3. (b) If veteran, name war No
3. (c) Social Security No. 500-146636

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ethel Clark
6. (c) Age of husband or wife if alive 27 years
7. Birth date of deceased Nov 11 1911
(Month) (Day) (Year)

8. AGE: Years 28 Months 11 Days 5
If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER
12. Name William Clark
13. Birthplace Unknown Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Melita Bunting
15. Birthplace Unknown Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel Clark
(b) Address Hurdley Mo

17. (a) Removal (b) Date thereof Oct 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield at Babcock

18. (a) Signature of funeral director F. W. Maples
(b) Address Chelver Mo

19. (a) 10-18-40 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Stone
(c) City or town Hurdley 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 Oct day 16
year 1940 hour 4 minute 30 P. M.
21. I hereby certify that I attended the deceased from Sept 19
1940 to Oct 16 1940
that I last saw him alive on Oct 16 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid
with hemorrhage → 1 day
Duration 5 wks

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy No Autopsy
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? NO (Specify type of place) (e) Means of injury _____

23. Signature Guy D Callaway (M. D. or other) _____
Address Springfield Mo Date signed 10/17/40

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

H

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 J. W. Maples
Licensed Embalmer No. 2985
P. O. Address Cluer 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.

X