

No. 2  
-13-40  
-17-39  
X23159

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Joseph Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community 32 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. 1 Merriam Kansas  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME James William Clark

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 487-07-3048

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Loleta 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased Sept. 29 1908  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	32	8	25	hr. min.

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

10. Usual occupation Structural Steel Worker

11. Industry or business Foley Bros Inc.

12. Name Michael Daniel Clark

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

14. Maiden name Frances M. Sherman

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

16. (a) Informant Mrs. Loleta Clark

(b) Address R.F.D. 1 Merriam Kansas

17. (a) Burial (b) Date thereof 6/28/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph Cem. Shawnee

18. (a) Signature of funeral director [Signature]

(b) Address 41st. State Line K.C.K.

19. (a) 6/26/41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 24 year 41 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
that \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Deceleration & Hemorrhage, Brain  
Fracture of the Skull  
Fall from Bldg. Const.

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

Major findings:  
Of operations 10 lobes  
18 lobes  
21

Of autopsy \_\_\_\_\_

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) Accident

(b) Date of occurrence 6-20-41

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Industrial  
(Specify type of place) (e) Means of injury Fall from Bldg. Const.

23. Signature Russell [Signature] (M.D. or other)  
Address K.C.M. Date signed \_\_\_\_\_

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

2048

999  
14  
0

2

MOTHER FATHER

2

**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.....

*Ross Blanford*

Licensed Embalmer No.....

*4015*

P. O. Address.....

*41<sup>st</sup> & State Line*

**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, fact should be so stated above.**