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FILED JUL 11 1941

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 449

Primary Registration District No. 4267

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County Laclede

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

(c) Name of hospital or institution: Wallace Memorial Hospital  
(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

3. (a) PRINT FULL NAME Infant Son of Mrs & Mrs Warren Clark

3. (b) If veteran, name war.....

3. (c) Social Security No. none

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased May 31 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

24 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name Warren Clark

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

14. Maiden name Mary Waterson

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

16. (a) Informant Warren Clark

(b) Address Competition mo

17. (a) burial (b) Date thereof 6 1 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Porter Cemetery

18. (a) Signature of funeral director H. H. ...

(b) Address.....

19. (a) 6-11-41 (b) J. A. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Laclede

(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1  
year 1941 hour 5 minute 45 AM.

21. I hereby certify that I attended the deceased from May 31, 1941, to June 1, 1941;  
that I last saw him alive on May 31, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of 7th Vertebra

Due to manipulation of delivery

Due to.....

Other conditions (include pregnancy within 3 months of death).....

Major findings: Of operations.....

Of autopsy.....

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 H. A. Hamilton (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File Number 7-41-1148

Date Filed 7-10-41

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.....

*No Embalming*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *W. E. Holman*.....

Licensed Embalmer No. *4107*.....

P. O. Address *Lebanon, 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, fact should be so stated above.

Registration District No. 449

Primary Registration District No. 4267

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Lebanon  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Infant Son of Mrs. Mrs. Warren 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 s

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 Months Days If less than one day \_\_\_\_\_ 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 Lebanon Mo

19. (a) 8-23-41 (b) J. A. McComb  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Laclede  
(c) City or town R. Franklin  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month June day 1  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
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? \_\_\_\_\_

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

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

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

SUPPLEMENTARY

