

HELD NOV 9 1942
Registration District No. 799

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson

(a) County: Jackson

(b) City or town: Kansas City

(c) Name of hospital or institution: 312 East 9th St.

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: XX (Specify whether)

In this community: 30 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State: Missouri (b) County: Jackson 3

(c) City or town: Kansas City 8

(d) Street No.: 312 East 9th St.

(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Charles H. Clarke

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. 19th day 1942

year 1942 hour 1: minute 50 A.M.

3. (b) If veteran, name war: No

3. (c) Social Security No.: 496-16-1514

21. I hereby certify that I attended the deceased from Sept 29 - 42 to Oct 18, 1942

that I last saw him alive on _____, 19____

and that death occurred on the date and hour stated above.

4. Sex: Ma

5. Color or race: Wh

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

Immediate cause of death: Phro-nosis creeping

6. (b) Name of husband or wife: Mattie J. Clarke

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

7. Birth date of deceased: November 22 1852

(Month) (Day) (Year)

Due to _____

Due to _____

Other conditions: Acidity

(Include pregnancy within 3 months of death)

8. AGE: Years 89 Months 10 Days 22

If less than one day: hr. min.

PHYSICIAN: _____

Underline the cause to which death should be charged statistically.

9. Birthplace: London England

(City, town, or county) (State or foreign country)

10. Usual occupation: Salesman

11. Industry or business: K.C. Towel Supply

12. Name: John Clarke

13. Birthplace: England

(City, town, or county) (State or foreign country)

14. Maiden name: Sarah Platte

15. Birthplace: England

(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Louie C. Lawson

(b) Address: 1219 E. 22nd Ave. N.K.C.

17. (a) Removal: Tuscumbia, Mo.

(b) Date thereof: 10-20-42

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Tuscumbia, Mo.

18. (a) Signature of funeral director: J.W. Wagner

(b) Address: Kansas City, Mo.

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: _____ (Date signed) _____

Address: 3937 Main

19. (a) 10-20-42 (Date received local registrar)

(b) M. H. Brown (Registrar's signature)

361

114-4113
2937
m
m

See page 2...

M. J. ...

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 *A. B. Hauschild*

Licensed Embalmer No. 4159

P. O. Address *H. E. 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No. **3860**

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

1. PLACE OF DEATH:

(a) County
(b) City or town
(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
In this community (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Charles H. Clarke**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced
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
89 yrs. 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
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address **17-2-42**
19. (a) **17-2-42** (b) **M. M. Crowe**
(Date received local registrar) (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.

20. DATE OF DEATH Month **Oct.** day **19th**
year **1947** hour minute M.

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

Immediate cause of death **Thrombosis creeping heart**

Due to
Due to
Other conditions **Senility**
(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)
While at work? (e) Means of injury

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

SUPPLEMENTAL COPY

3937 main street

MOTHER FATHER

32059