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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10165

State File No. 7

FILED APR 24 1943  
Registration District No. 111

Primary Registration District No. 5426 Registrar's No. 7

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Labadie MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Beth. Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin  
(c) City or town Labadie  
(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

3. (a) PRINT FULL NAME MARY MATTHEWS CLARK

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

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 27 1864  
(Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Bathing Rug Cal.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Agie Scott

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

14. Maiden name unknown

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

16. (a) Informant Bilateral Perkins

(b) Address 1113 Union Alton Ill

17. (a) Burial (b) Date thereof 3-25-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lamp's Cemetery, Labadie

18. (a) Signature of funeral director John W. Hendrick

(b) Address 4608 S. Filmore Av. Richmond MO

19. (a) 3/23/43 (b) \_\_\_\_\_  
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19  
year 1943 hour 4:30 minute 0 M.

21. I hereby certify that I attended the deceased from 1942 Aug.  
19 \_\_\_\_\_ to March 19 1943  
that I last saw her alive on March 18 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor Duration \_\_\_\_\_

Due to Carcinoma of the transverse colon

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 462

Major findings: Of operations \_\_\_\_\_

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) \_\_\_\_\_

(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 J. L. Toss (M. D. or other) \_\_\_\_\_

Address Washington Date signed March 20 43

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

1110

(Licensed Embalmer's Statement on Reverse Side)

**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

*myself*

Registered Apprentice No.

working under my personal supervision

Signed

*A. C. Houston*

Licensed Embalmer No.

*2264*

P. O. Address

*2912 Kings St. Suite 101*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10165  
Registrar's No. 7

Registration District No. 111 Primary Registration District No. 5426

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Sabodis  
(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 30 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Mary M. Clark  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 27 1913 (Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days 25 (If less than one day, in min.)  
9. Birthplace La. (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry of business \_\_\_\_\_  
MOTHER FATHER { 12. Name Wm Scott  
13. Birthplace Wick (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Bulah Peckham  
(b) Address 1113 Union altar st  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-43 (Month) (Day) (Year)  
(c) Place: burial or cremation Sabodis Cemetery  
18. (a) Signature of funeral director John W. Marshall  
(b) Address \_\_\_\_\_  
19. (a) 3/23/43 (Date received local registrar) (b) Clarence C. Fletcher (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 bronchitis pneumonia Duration \_\_\_\_\_

Due to Carcinoma of the Transverse Colon  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
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) \_\_\_\_\_  
(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

