

AUG 23 1943

Registration District No. 128

Primary Registration District No. 5465

1. PLACE OF DEATH:

(a) County. Greene  
(b) City or town. rt. 4 city N. Campbell  
(c) Name of hospital or institution: Greene County Hospital  
(d) Length of stay: In hospital or institution. Three Weeks  
In this community. 55 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Greene  
(c) City or town. Rural, N. Campbell  
(d) Street No. Rt. 4 city  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Robert Calvin Clark

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

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

6. (b) Name of husband or wife. None 6. (c) Age of husband or wife if alive. XX years

7. Birth date of deceased. November 14th 1869

8. AGE: Years 73 Months 8 Days 27

9. Birthplace. Springfield, Tenn.

10. Usual occupation. Farmer

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

12. Name. William Haywood Clark

13. Birthplace. Tenn. Ark. Tenn.

14. Maiden name. Polly Porter

15. Birthplace. Springfield, Tenn.

16. (a) Informant. Mrs. Flossie Clark

(b) Address. 1010 W. Dale, Spfld, Mo.

17. (a) Burial (b) Date thereof. 8-14-43

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

18. (a) Signature of funeral director. Dunn Funeral Home

(b) Address. 629 W. Walnut, Springfield, Mo

19. (a) 8-13-43 (b) Dr. W.S. Haulley

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month. Aug. day 11th. year 1943 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from About July 28 1943 to Aug 11 1943 that I last saw him alive on Aug 11 1943 and that death occurred on the date and hour stated above.

Immediate cause of death. Arteriosclerosis, general malnutrition.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions. 97  
(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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 8-12-43

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

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**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.....

*Clarence W. McEachern*

Licensed Embalmer No.....

*2891*

P. O. Address.....

**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.**

*X*