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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3572

FILED FEB 14 1944

Registration District No. 1344 Primary Registration District No. 5776 Registrar's No. 13

1. PLACE OF DEATH:

(a) County Mercer

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

(c) Name of hospital or institution: at / home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community life time
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County 65

(c) City or town ..... (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 0

3. (a) PRINT FULL NAME ALMEDA MABEL CLARK

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

3. (c) Social Security No. .....

4. Sex female

5. Color or race white

6. (a) Single, widowed, married. 2 divorced Widow

6. (b) Name of husband or wife husband J. D Clark

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

7. Birth date of deceased Mar (Month) 29 (Day) 1866 (Year)

8. AGE: Years 83 Months 10 Days 5 If less than one day ..... hr. ..... min.

9. Birthplace Mercer County (City, town, or county) Mo (State or foreign country)

10. Usual occupation house wife

11. Industry or business .....

FATHER
12. Name Ruben Perkins
13. Birthplace Tennessee (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mariah - Rhea
15. Birthplace Tenn (City, town, or county) (State or foreign country)

16. (a) Informant A. C. Milner
(b) Address Mill Grove

17. (a) Gosen (Burial, cremation, or removal) (b) Date thereof Jan 26 44 (Month) (Day) (Year)
(c) Place: burial or cremation Burial

18. (a) Signature of funeral director H S R Person
(b) Address Jamesport Mo

19. (a) 1-28-44 (Date received local registrar) (b) Leon Martin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 23 day 1944
year 1944 hour 10 45 minute ..... M.

21. I hereby certify that I attended the deceased from January 17, 1944, to January 23, 1944, that I last saw her alive on January 18, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	1 week
Due to ✓	
Due to ✓	
Other conditions (Include pregnancy within 3 months of death) 830	
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? ✓ (Specify type of place)

While at work? ✓ (e) Means of injury ✓

23. Signature C. L. McClanahan (M. D. or other) M.D.
Address Spickard Mo Date signed Jan 25 44

1367

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed H. S. Roberson

Licensed Embalmer No. 3001

P. O. Address Jamesport Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

1. PLACE OF DEATH:
(a) County Mercer
(b) City or town Rural
(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 years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Mercer
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. E of Mill Grove, Mo (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Almeda M. Clark
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____
4. Sex F
5. Color or race W
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 Mar. (Month) 29 (Day) ____ (Year)
8. AGE: Years 83 Months 10 Days ____ If less than one day ____ hr. ____ min.
9. Birthplace ____ (City, town, or county) Mo. (State or foreign country)
10. Usual occupation ____
11. Industry or business ____
MOTHER FATHER
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) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director ____
(b) Address ____
19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 3 year 1944 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.

	Duration
Immediate cause of death	
Due to	
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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature ____ (M. D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY

3572