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FILED MAR 9 1944

State File No.

Registration District No.

Primary Registration District No. 6090

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Saline
(b) City or town St. Leonard
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline
(c) City or town St. Leonard
(If outside city or town limits, write "RURAL")
(d) Street No. Mo P.O.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM CLARK

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

4. Sex M 5. Color or race 2 Negro 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Sada Clark 6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased April 1 1853
(Month) (Day) (Year)

8. AGE: Years 86 Months 10 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Teacher of Schools

11. Industry or business _____

MOTHER FATHER

12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 7
(City, town, or county) (State or foreign country)

16. (a) Informant Ester Gray

(b) Address Marshall Mo

17. (a) Burial (b) Date thereof 2 9 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maltaban Mo

18. (a) Signature of funeral director E. P. Ferguson

(b) Address Sada Lee, Mo

19. (a) 2-9-1944 (b) Mrs. Don Hoffmann
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4th year 1944 hour 11 minute P M.

21. I hereby certify that I attended the deceased from 2 - 2nd 44 to 2 - 4th 44 1944
that I last saw him alive on 2 - 4th 44 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis chronic
Due to arteriosclerosis and nephritis
Due to _____

Other conditions (Include pregnancy within 3 months of death) 12/8
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 0

23. Signature Geo A. Kelling (M. D. or other)
Address Waverly Mo Date signed 2-5-44

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

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 3-8-44

NOV 6 1934

RECEIVED

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 F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Sedalia

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. 323 Primary Registration District No. 6090

1. PLACE OF DEATH:
 (a) County Salem
 (b) City or town Mt. Leonard Liberty
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: supp
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 40 yrs in Mt. Leonard (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Clark
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race B
 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife Sada 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April (Month) (Day) (Year)

8. AGE: Years 86 Months 12 Days 18 (If less than one day, min.)
 9. Birthplace _____ (City, town, or county) (State or foreign country) mo.

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)
(Burial, cremation, or removal)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) 2/9 44 (b) Mrs Don Hoffmann
(Date received local registrar) (Registrar's signature)

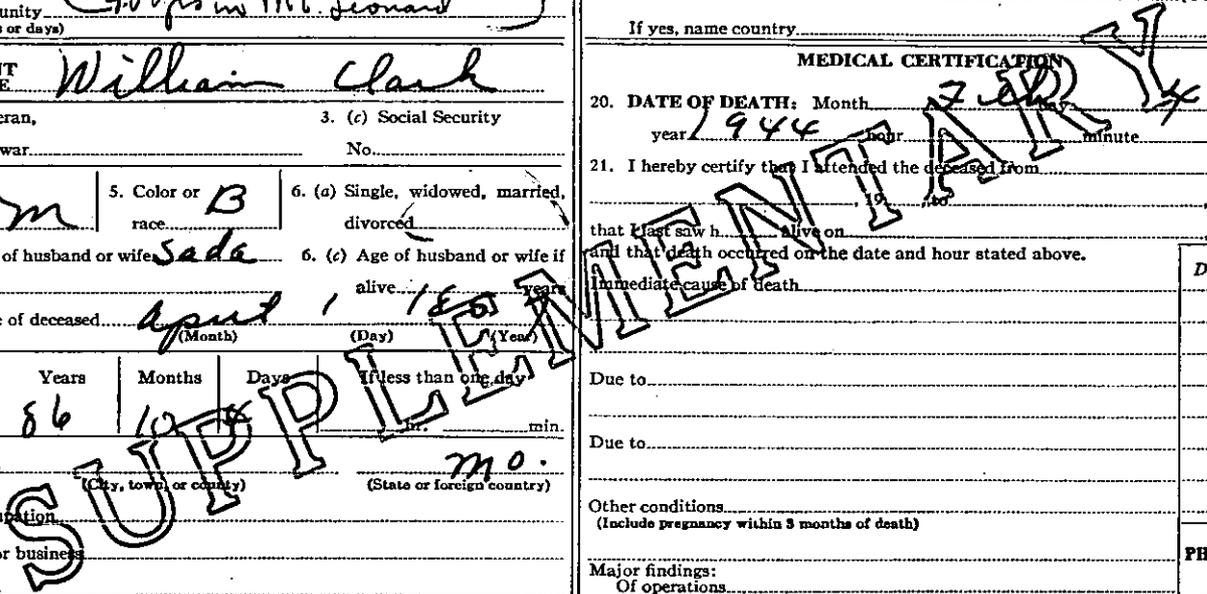
2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March year 1944 hour _____ minute _____ M. _____
 21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ 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 _____
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



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