

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 7 1945
1945

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 900

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

1. PLACE OF DEATH
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Little Sisters 53rd & Highland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
(Specify whether
In this community 58 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
Missouri
(a) State _____ (b) County Jackson
(c) City or town KANSAS CITY, MO
(If outside city or town limits, write "RURAL")
(d) Street No. 5030 FOREST
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs Lena M. CLARK

MEDICAL CERTIFICATION

3. (b) If veteran, name war None 3. (c) Social Security No. None

20. DATE OF DEATH: Month February day 23rd
year 1945 hour 7:45 minute P M.

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John E. Clark 6. (c) Age of husband or wife if alive 61
7. Birth date of deceased July 8th 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec-1-1944
_____, 19____, to Feb 23, 1945
that I last saw her alive on Feb 20, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
83 7 15 hr. min.

Immediate cause of death Brownish pneumonia Duration 2 days
Due to hypertensive heart disease 7 min

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

Due to arteriosclerosis year

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business at Home

Major findings: Of operations 93 d. Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

12. Name Bernard Wendell
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Baughman
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Edward Flynn
(b) Address 5030 Forest

17. (a) Burial (b) Date thereof 2-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

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? _____

18. (a) Signature of funeral director Melody McElly
(b) Address R. C. 2nd

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature J. T. Shaver (M. D. or other) MD
Address 1102 Grand Ave. N. E. C. Mo. Date signed 2-23-45

19. (a) 2-24-45 (b) H. E. Brown
(Data received local registrar) (Registrar's signature)

NO
SHE...
... ..

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.....
Licensed Embalmer No.....
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.