

5330

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 12 1945
Registration District No.

Primary Registration District No. 3056

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Prosperville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCormick Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 da
(Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chautauq
(c) City or town RR 21
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William R. Clark

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 18 - 1866
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Balen Clark
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Johnson
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Frankie Dooley
(b) Address Keytesville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 - 45
(Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Delbert Skunk

(b) Address Macon Mo

19. (a) 2-17-45 (Date received local registrar) (b) Wm Havel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 13
year 1945 hour 2 minute 45 M.

21. I hereby certify that I attended the deceased from 2-13, 1945, to 2-15, 1945
that I last saw him alive on 2-15, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Staphylococcus infection right leg
Due to ax cut of knee
1 in long thru skin
Due to _____

Duration

7 da

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

Major findings:
Of operations _____
Of autopsy _____

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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)
(g) Means of injury _____
23. Signature W P McCormick (M. D. or other) MD
Address Prosperville Mo Date signed 2-15-45

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

1036

RECEIVED

District Health Officer No. 10

District File Number 3-45-512

Date Filed MAR 9 1945

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 Albert Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon mo

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6930
Registrar's No. 32

Registration District No. 294 Primary Registration District No. 3056

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(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 _____)
In this community _____
years, months or days

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife, if alive _____
7. Birth date of deceased Aug 18 1866
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 2 If less than one day _____
hr. _____ min. _____

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

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data 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 _____

20. DATE OF DEATH: Month Feb day _____
year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus infection
Left knee
Due to Cut on Left knee
Due to _____

Other conditions _____ (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) accident
(b) Date of occurrence _____
(c) Where did injury occur? Keosauville Chautau mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? yes (Specify type of place) (c) Means of injury cut on knee
23. Signature W. L. McCormick (M. D. or other) M.D.
Address Moberly mo Date signed 2-22-46

SUPPLEMENTARY

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

