

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36905
Registrar's No. 5790A

FILED NOV 25 1946
Registration District No. 779

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: Research Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 1 week
(If not in hospital or institution, write street number or location)

In this community 40 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. Drake Hotel, 1016 Locust Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ANDREW B. CLARK

3. (b) If veteran, name war No

3. (c) Social Security No. 486-01-0179

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Barbara Clark

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased November 25th, 1901
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>44</u>	<u>11</u>	<u>17</u>	hr. _____ min. _____

9. Birthplace Tipton Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Wolf Brothers

MOTHER FATHER

12. Name A. P. Clark

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

14. Maiden name Marcella Whitfield

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Barbara Clark

(b) Address Drake Hotel, 1016 Locust Street

17. (a) Burial (b) Date thereof 11-14-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Moriah Cemetery

18. (a) Signature of funeral director Freeman Mortuary & Chapel

(b) Address 104 West 42nd, St., Kansas City, Mo.

19. (a) 11-13-46 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 12th.
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Oct. 31, 1946 to 11-12, 1946.
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis from ruptured diverticulum at apex of cecum

Duration _____

Due to ruptured diverticulum at apex of cecum

Due to peritonitis

Other conditions terminal pneumonia
(Include pre-mortem conditions)

Major findings:
Of operations _____

Of autopsy at nec. 12/3

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 [Signature] M.D. or other _____

Address [Address] Date signed 11-12-46

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.

from 211 to St 01/11