DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 19 1946

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 40511

Registrar's No. 5138

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: Research Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 16 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 46

(a) State Missouri (b) County Jackson 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 514 Brookside
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME LEVI EARL CLARK

3. (b) If veteran, name war None

3. (c) Social Security No. none

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Laura Clark

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

7. Birth date of deceased June 11th (Month) 1884 (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
62	5	25	hr. min.

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

10. Usual occupation Carpenter

11. Industry or business self

FATHER
12. Name Charles Clark
13. Birthplace Mammouth, Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Josephine Earp
15. Birthplace Mammouth, Illinois (City, town, or county) (State or foreign country)

16. (a) Informant Laura Clark
(b) Address 514 Brookside

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-9-46 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director George C. Carson
(b) Address Independence, Missouri

19. (a) 12-7-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month December day 6
year 1946 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from December 4, 1946, to December 6, 1946; that I last saw him alive on Dec 6, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Triplo coccic Septicaemia? Blood culture reported positive today (Dec 7, 1946)

Due to: Source of infection unknown

Due to: Vegetations in aorta, Areas of encephalomalacia, Early pneumonia, Uraemia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy See above

Duration ?

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Earl R Ferris (M. D. or other) MD
Address 934 Argyle Bldg Kansas City, Mo Date signed 12-7-46

(Licensed Embalmer's Statement on Reverse Side)

JAN 31 1951

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 Charles F. Tyler, Registered Apprentice No. 411 working under my personal supervision.

Signed R. A. Lisle

Licensed Embalmer No. 4123

P. O. Address Independence

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

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

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STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5138

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: Research Hosp.
(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 ..... (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 .....

3. (a) PRINT FULL NAME: Levi Earl Clark

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

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

4. Sex .....

5. Color or race .....

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

6. (b) Name of husband or wife .....

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

7. Birth date of deceased ..... (Month) ..... (Day) ..... (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

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

MOTHER
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) 12-7-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. Day ..... year 1946 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19..., that I last saw him alive on ..... 19..., and that death occurred on the date and hour stated above.

Immediate cause of death: Streptococcic septicemia? blood culture reported positive today (12-7-46)

Due to: pneumococcus type 22.

Due to: source of infection unknown. vegitation in aorta

Other conditions: areas of encephalomalacia
(Include pregnancy within 3 months of death)

early pneumonia, uremia

Major findings:
Of operation: none. 83 C

Of autopsy: see above.

Duration

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: Carl R. Ferris (M. D. or other)

Address: 934 Argyle Bldg. Date signed: 12-7-46

SUPPLEMENTARY

40511