

No. 2  
9-43  
7-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State, File No. **4110**

Registration District No. **43**

Primary Registration District No. **3007**

Registrar's No. **77**

**1. PLACE OF DEATH:**

(a) County BUTLER

(b) City or town POPLAR BLUFF  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
BRANDON HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 DAYS  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** MARTIN SIMMS 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 UNKNOWN

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

7. Birth date of deceased FEB 13 1965  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>81</u>	<u>11</u>	<u>19</u>	<u>✓</u> hr. <u>✓</u> min.

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

10. Usual occupation TIMBER WORKER

11. Industry or business TIMBER

**MOTHER FATHER**

12. Name DAVE CLARK

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

14. Maiden name TERSA WARRER

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

16. (a) Informant MRS MARLER

(b) Address WILLIAMSVILLE MO

17. (a) BURIAL (b) Date thereof FEB 4 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WILLIAMSVILLE MO

18. (a) Signature of funeral director N.W. [Signature]

(b) Address Poplar Bluff, Mo.

19. (a) 2/24/47 (b) R.W. Minettee  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County WAYNE

(c) City or town WILLIAMSVILLE MO  
(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 \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month FEB day 2  
year 1947 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 2, 1947, to Feb 2, 1947  
that I last saw him alive on Feb 2, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Failure

Due to Intercostal Chanting

Due to Fracture of R. Femur

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations 1867

Of autopsy 1867

**ADDITIONAL PHYSICIAN SUPPLEMENTARY INFORMATION REQUESTED**

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

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Jan 2 - 1947

(c) Where did injury occur? Home  
(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) Home

While at work? \_\_\_\_\_ (e) Means of injury D

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Poplar Bluff, Mo. Date signed 2-23-47

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

RECEIVED

District Health Office No. 2,

District File Number 347-310

Date Filed 3-4-47

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.....

*me*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed *Marvin E. Bowler*

Licensed Embalmer No. 4427

P. O. Address *Redman, Mo*

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

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

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Bates  
(b) City or town Poplar Bluff  
(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 (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Martin 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 \_\_\_\_\_ (less than one day) \_\_\_\_\_ min.

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

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

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 Feb year 1947 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 Fracture femur  
Fall on ice

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) \_\_\_\_\_

(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 Franklin M. D. (M. D. or other) \_\_\_\_\_  
Address Poplar Bluff, Mo. Date signed \_\_\_\_\_

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

5-4110