

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20501**

No. 12-5
3-39
X-4790

FILED JUL 15 1947

Registration District No. **116**

Primary Registration District No. **3020**

Registrar's No. **99**

1. PLACE OF DEATH:
(a) County **Franklin.**
(b) City or town **Washington.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Francis Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 hour.**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Franklin**
(c) City or town **Washington**
(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 **Baby Clark.**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **X** 6. (c) Age of husband or wife if alive **X** years

7. Birth date of deceased **July 7th, 1947**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	0	0	1 hr. min.

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

10. Usual occupation **X**

11. Industry or business **X**

12. Name **Carl Melburn Clark.**

13. Birthplace **Freedom, Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Anastasia Knaus.**

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

16. (a) Informant **Mr. Carl Clark**

(b) Address **204 Fair St. Washington, Mo.**

17. (a) **Burial** (b) Date thereof **July 7, 1947.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington, Mo.**

18. (a) Signature of funeral director **Nielborg & Vitt, Inc.**

(b) Address **Washington, Mo.**

19. (a) **7/7/47** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **7th.**
year **1947** hour **6:00** minute **A.M.**

21. I hereby certify that I attended the deceased from **5:15 a.m.**
7/7, 1947, to **6 a.m. 7/7**, 1947;
that I last saw her alive on **5:45 a.m. 7/7**, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardio-respiratory failure** Duration **45 Min**

Due to **pre-maturity (5 Mo. gestation)**

Due to **pre-mature separation of placenta (oblate placenta)**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **159**
Of autopsy

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) (e) Means of injury **0**

23. Signature **Michael S. Hoffrich** (M. D. or other) **M.D.**

Address **Washington, Mo.** Date signed **7/7/47**

WRITE PLAINLY—USE UNFADING BLACK INK—RECORD

Dr. Hoffrich

RECEIVED
District Health Officer No. 9,
District File Number 7-14-47
Date Filed

82 1987
JAN 1987

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

Not Embalmed

Registered Apprentice No.

working under my personal supervision.

Signed

Lester H. Witt

Licensed Embalmer No.

13254

P. O. Address

Washington, D.C.

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.

Registration District No. 116

Primary Registration District No. 3020

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Washington
(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

Clark

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

4. Sex m 5. Color w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

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) Mo

10. Usual occupation _____

11. Industry or business

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) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

5-20501