

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23327

FILED JUL 20 1948
Registration District No. 155

Primary Registration District No. 3127

Registrar's No. 101

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
20 1/2 S. Main St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 30yrs
years, months or days)

3. (a) PRINT FULL NAME ETHEL CORDELIA CLARK

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

4. Sex female 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife C.L. Clark 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 4, 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 11 6 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas E. Overline

13. Birthplace LaClade County, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Martha E. Sanders

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

16. (a) Informant C.L. Clark

(b) Address 20 1/2 S. Main Webb City, Mo.

17. (a) Burial (b) Date thereof July 12, 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carterville Cemetery

18. (a) Signature of funeral director Hedge-Lewis

(b) Address Webb City, Missouri

19. (a) JULY 12, 1948 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Webb City, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 20 1/2 S. Main
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10
year 1948 hour 2:15 minute _____ A. M.

21. I hereby certify that I attended the deceased from Dec 12
1947, to July 10 1948
that I last saw her alive on July 7 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia, tachycardia
Due to bleed in left chest
Due to Carcinoma - metastatic

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

Major findings: Of operations _____

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 [Signature] (M. D. or other)
Address Webb City, Mo. Date signed 7/10/48

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

MOTHER, FATHER

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

48-6-598

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.....

Leonard J. Lewis Jr.

Registered Apprentice No. *46*

working under my personal supervision.

Signed.....

Richard Gray Lewis

Licensed Embalmer No. *4695*

P. O. Address *Webb City, 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. *aug*

Registration District No. *15-5*

Primary Registration District No. *3127*

Registrar's No. *107*

1. PLACE OF DEATH:

(a) County *Jasper*
(b) City or town *Webb City*
(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 *Ethel C. Clark*

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

4. Sex *F* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *m*

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

7. Birth date of deceased: *aug 4* (Month) (Day) (Year)

8. AGE: Years *61* 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 _____

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) _____ (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) _____ (Date received local registrar) (b) _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *1948* year *19* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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 *L*

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

Address _____ Date signed _____

SUPPLEMENTARY

Primary date unknown.

S-23327

Handwritten notes, possibly including "11/11/11" and "11/11/11", written in a cursive style.