

FILED NOV. 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 399910

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

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6226 Registrar's No. 185

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri COUNTY Vernon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Coal Twp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Coal Township	
d. FULL NAME OF HOSPITAL OR INSTITUTION R.F.D. 1 Ft. Scott, Kansas		d. STREET ADDRESS (If rural, give location) R.F.D. No. 1 Ft. Scott, Kansas	
3. NAME OF DECEASED (Type or Print) Ernest		a. (First) Ernest	
b. (Middle) _____		c. (Last) Clark	
4. DATE OF DEATH (Month) (Day) (Year) Nov. 10, 1949		5. SEX male	
6. COLOR OR RACE wht. Am.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) married	
8. DATE OF BIRTH Dec. 21, 1878		9. AGE (In years, months, days, hours, minutes) 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Stockman	
11. BIRTHPLACE (State or foreign country) Greenberg, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Gottlieb Clark		13b. MOTHER'S MAIDEN NAME Emelia Boyer	
14. NAME OF HUSBAND OR WIFE Katie Lenges		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Katie L. Clark, (Wife) R. D. No. 1 Ft. Scott, Kan.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 1, 1949 to Nov 10, 1949 , that I last saw the deceased alive on Nov 9, 1949 , and that death occurred at ZISSA, mi , from the causes and on the date stated above.			
23a. SIGNATURE James F. Lewis M.D.		23b. ADDRESS 215 E. 1st York Scott Kans	
23c. DATE SIGNED 11-12-49		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE Nov. 13, 1949		24c. NAME OF CEMETERY OR CREMATORY Deerfield Cemetery	
24d. LOCATION (City, town, or county) (State) Deerfield, Missouri		DATE REC'D BY LOCAL REG. Nov 14, 1949	
REGISTRAR'S SIGNATURE Walter H. Hansen		331	
25. FUNERAL DIRECTOR'S SIGNATURE O. A. Cheney		ADDRESS Ft. Scott, Kan	

RECEIVED
District Health Officer No. 7;
District File Number 10-49-1375
Date Filed 11-21-49

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 _____

Student Embalmer No. 2612

working under my personal supervision.

Student
Student Embalmer

Signed *W. C. Cherry*

Licensed Embalmer No. 2612

P. O. Address Fort Scott, Kansas

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.