

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9160**

FILED MAR 25 1953

BIRTH NO.		REG. DIST. NO. 71	PRIMARY REG. DIST. NO. 3012	Registrar's No. 33
1. PLACE OF DEATH a. COUNTY CLAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY CLAY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EXCELSIOR SPRINGS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EXCELSIOR SPRINGS		
d. FULL NAME OF HOSPITAL OR INSTITUTION EXCELSIOR HOSPITAL		d. STREET ADDRESS (If rural, give location) 6002 528 REGENT ST. 0		
3. NAME OF DECEASED (Type or Print) a. (First) JAMES		b. (Middle) ALLEN		c. (Last) CLARK
4. DATE OF DEATH (Month) (Day) (Year) MAR. 20, 1953		5. SEX MALE		6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH NOV. 25, 1901		9. AGE (In years last birthday) 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOTEL		10b. KIND OF BUSINESS OR INDUSTRY ASSISTANT MANGER		11. BIRTHPLACE (State or foreign country) LAWSON, MO
12. CITIZEN OF WHAT COUNTRY? USA.		13a. FATHER'S NAME ROBERT J. CLARK		
13b. MOTHER'S MAIDEN NAME MARIE JOSEPHINE ALLEN		14. NAME OF HUSBAND OR WIFE FLORENCE BRITT CLARK		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 500-07-7800		17. INFORMANT'S SIGNATURE OR NAME Mrs. Thelma Clark ADDRESS Excelsior Springs, Mo.
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH not ANTECEDENT CAUSES Morbid 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		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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)		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 3-20-1953 to 3-20-1953 that I last saw the deceased alive on 3-20-1953 and that death occurred at 9:00 p.m. , from the causes and on the date stated above.				
23a. SIGNATURE E. E. Fay (Degree or title)		23b. ADDRESS Richwood		23c. DATE SIGNED 3-21-53
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAR. 22/53		24c. NAME OF CEMETERY OR CREMATORY LAWSON CEMETERY
24d. LOCATION (City, town, or county) (State) LAWSON MO.		25. FUNERAL DIRECTOR'S SIGNATURE HOPE FUNERAL HOME ADDRESS by Wengal Hope 216 Spring Ex. Spg. Mo.		
DATE REC'D BY LOCAL REG. 3/23/53		REGISTRAR'S SIGNATURE Caroline Hutchings 62-0		

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

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. _____

working under my personal supervision.

Student _____

Student Embalmer

Signed



Licensed Embalmer No. 03458

P. O. Address *Carolina Springs, 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.