

FILED OCT 15 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33016**
Registrar's No. **8719**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Butler	
b. CITY OR TOWN St. Louis, Missouri		c. CITY OR TOWN South Poplar Bluff	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) South Poplar Bluff	
3. NAME OF DECEASED (Type or Print) a. (First) MABEL b. (Middle) Myona c. (Last) CLARK		4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 2, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8-25-1909
9. AGE (In years last birthday) 44		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Worthington Ind.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME James Bender	
13b. MOTHER'S MAIDEN NAME Clara Hoffman		14. NAME OF HUSBAND OR WIFE Harry Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No Nil		16. SOCIAL SECURITY NO. *****	
17. INFORMANT'S SIGNATURE OR NAME Elsie Francis Fisk Mo.		ADDRESS	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Unknown ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of cervix 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) 171X			
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 1-26-53 , 19____, to 9-2-53 , 19____, that I last saw the deceased alive on 9-2-53 , 19____, and that death occurred at 1:45P m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Kathleen Smith		23b. ADDRESS M.D. 1420 Grattan	
23c. DATE SIGNED 9-3-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-3-53	
24c. NAME OF CEMETERY OR CREMATORY Shain Memorial		24d. LOCATION (City, town, or county) (State) Butler Missouri	
DATE REC'D BY LOCAL REG. SEP 8 1953		REGISTRAR'S SIGNATURE J. Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd.	

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
Signature of Student Embalmer

Signed *J. Wm. Bentley*

Licensed Embalmer No. *3653*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.