

FILED JUL 6 1954

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18743

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY HOWELL		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY HOWELL	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WEST PLAINS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WEST PLAINS	
c. LENGTH OF STAY (in this place) 3 yrs		d. STREET ADDRESS (If rural, give location) SHUTTEE STR.	
d. FULL NAME OF HOSPITAL OR INSTITUTION CHRISTA HOGAN HOSPITAL			

3. NAME OF DECEASED (Type or Print) WILLIAM C. CLARKSON			4. DATE OF DEATH 5-27-54 (Month) (Day) (Year)				
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH 5-27-54	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY West Plains Livestock		11. BIRTHPLACE (State or foreign country) SHELBY CO., MISSOURI		12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME JAS. W. CLARKSON		13b. MOTHER'S MAIDEN NAME MARY BROWNING		14. NAME OF HUSBAND OR WIFE LILLIAN CLARKSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. X		17. INFORMANT'S SIGNATURE OR NAME LILLIAN CLARKSON, WEST PLAINS, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema 2 days		INTERVAL BETWEEN ONSET AND DEATH 2 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Infarction 5 weeks			
		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **11-4, 1952** to **5-27, 1954**, that I last saw the deceased alive on **5-27, 1954**, and that death occurred at **6:15 PM** from the causes and on the date stated above.

23a. SIGNATURE: Jack N. Wilson, M.D.		(Degree or title)		23b. ADDRESS West Plains, Mo		23c. DATE SIGNED 6-4-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) B		24b. DATE 5-29-54		24c. NAME OF CEMETERY OR CREMATORY OAK LAWN		24d. LOCATION (City, town, or county) (State) WEST PLAINS, MO	

DATE REC'D BY LOCAL REG. 7-2-54		REGISTRAR'S SIGNATURE Beatrice Cook		379-		25. FUNERAL DIRECTOR'S SIGNATURE ROBERTSONS, WEST PLAINS, MO		ADDRESS	
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WRITE PLAINLY—USING UNFAADING 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

J. D. Roberts

Licensed Embalmer No. *343*

P. O. Address *West Plains*

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.