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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12329

FILED MAY 3 1955

BIRTH NO. 23906-55 REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar's No. 169

1. PLACE OF DEATH
a. COUNTY: Jasper
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Joplin
c. LENGTH OF STAY (in this place): 8 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Freeman Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oklahoma
b. COUNTY: Ottawa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Peoria 835 0 8
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Connie
b. (Middle): Diane
c. (Last): Clark

4. DATE OF DEATH (Month) (Day) (Year): April 26, 1955

5. SEX: Female 1
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: April 25, 1955
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 8 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----------
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): Joplin, Missouri 0
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Creslie Clark
13b. MOTHER'S MAIDEN NAME: Velma Wight
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): -----
(If yes, give war or dates of service): -------
16. SOCIAL SECURITY NO.: -----
17. INFORMANT'S SIGNATURE OR NAME: Creslie Clark
ADDRESS: Peoria, Oklahoma

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) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: At Birth

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 7620
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/25/, *1955, to* 4/26, *1955, that I last saw the deceased alive on* 4/26/, *1955, and that death occurred at* 3 a *m., from the causes and on the date stated above.*

23a. SIGNATURE Alice H Wilson M D (Degree or title) M D
Alice H Wilson M D
23b. ADDRESS: 1923 Sergeant, Joplin, Mo
23c. DATE SIGNED: 4/29/55

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 4-27-1955
24c. NAME OF CEMETERY OR CREMATORY: Decatur Cemetery
24d. LOCATION (City, town, or county) (State): Decatur, Arkansas

DATE REC'D BY LOCAL REG. 4-30-55
REGISTRAR'S SIGNATURE 138 0
25. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Siloam Springs Arkans

(Licensed Embalmer's Statement on Reverse Side)

Date Filed MAY 2 1955

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 [signature]

Licensed Embalmer No. 32 11

P. O. Address Siloam Springs a

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.