

RECEIVED MAY 31 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16857

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 2058 Registrar's No. 119

1. PLACE OF DEATH a. COUNTY ST CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST CHARLES	
b. CITY (If outside corporate limits, write RURAL and give town) ST CHARLES.		c. LENGTH OF STAY (in this place) 2 YRS	c. CITY OR TOWN ST CHARLES.
d. FULL NAME OF HOSPITAL OR INSTITUTION OLIVE 1037		STREET ADDRESS (If rural, give location) 1037 OLIVE ST. 0923	

3. NAME OF DECEASED a. (First) WILLIAM b. (Middle) _____ c. (Last) CLARK.			4. DATE OF DEATH (Month) (Day) (Year) MAY 23 1955		
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY GRAIN & STOCK		8. DATE OF BIRTH UNK.	
11. BIRTHPLACE (City and State or Foreign Country) LINCOLN Co. MO			9. AGE (In years last birthday) 45? IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
13a. FATHER'S NAME CHARLEY CLARK.			13b. MOTHER'S MAIDEN NAME ? CHANEY		14. NAME OF HUSBAND OR WIFE JESSIE CLARK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. UNK.		17. INFORMANT'S SIGNATURE AND NAME HETTIE BEEN MOSCOW MILLS 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) Proteinuria, lobar			INTERVAL BETWEEN ONSET AND DEATH 1 week
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Vascular Thrombosis			2 years
		DUE TO (c) Arteriosclerotic Heart Disease			Unknown
		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?	

22. I hereby certify that I attended the deceased from March 20, 1955, to May 23, 1955, that I last saw the deceased alive on May 7, 1955, and that death occurred at 7:50P m., from the causes and on the date stated above.

23a. SIGNATURE F. R. Reeves M.D. (Degree or title)		23b. ADDRESS St. Charles, Mo.		23c. DATE SIGNED May 24, 1955	
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE 5/27/55		24c. NAME OF CEMETERY OR CREMATORY TROY CEM.	
				24d. LOCATION (City, town, or county) (State) TROY, MO.	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE May 24 1955		REG. NO. 244-1		25. FUNERAL DIRECTOR'S SIGNATURE MEMBER FUNERAL HOME TROY MO. ADDRESS	
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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.....
Signature of Student Embalmer

Signed *Joseph J. Marsh*
Licensed Embalmer No. *393*

P. O. Address *Troy, 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.