

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4633

State File No. _____
Registrar's No. **631**

FILED MAR 4 1957

BIRTH NO. 2644-57 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>LAFAYETTE</u>		
b. CITY OR TOWN <u>KANSAS CITY, MO</u>		c. LENGTH OF STAY (in this place) <u>3 1/2 hrs</u>	c. CITY OR TOWN <u>Lexington</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Ch. Idreus Mercy Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>Cottonwood St.</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u>		b. (Middle) <u>WAYNE</u>	c. (Last) <u>CLARK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-7-57</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, or WIDOWED, DIVORCED (Specify) <u>INFANT</u>	8. DATE OF BIRTH <u>1-19-57</u>	9. AGE (In years last birthday) <u>18</u>	IF UNDER 1 YEAR Months <u>23</u> Days <u>18</u> Hours <u>23</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Lexington Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Decatur Clark</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hopkey</u>		14. NAME OF HUSBAND OR WIFE <u>Infant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Decatur Clark</u>		ADDRESS <u>Lexington Mo</u>	
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) <u>Bilateral bronchopneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Aspiration</u> DUE TO (c) <u>Double bilateral cleft palate</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 755x				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <u>7</u> (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 <u>2-4-</u> , 1957, to <u>2-7-</u> , 1957, that I last saw the deceased alive on <u>2-7-</u> , 1957, and that death occurred at <u>10:50</u> a.m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Wayne Hart</u> (Degree or title) <u>MD</u>			23b. ADDRESS <u>1710 Indep Ave, K.C. Mo</u>		23c. DATE SIGNED <u>2-8-57</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>2-8-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lexington Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Lexington, MO</u>		
DATE REC'D BY LOCAL REG. <u>2-9-57</u>		REGISTRAR'S SIGNATURE <u>never mindall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Temple F.H. Lexington Mo</u> ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address

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.