

FILED APR 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15808

BIRTH NO. 2P195-57 REG. DIST. NO. 319 PRIMARY REG. DIST. NO. 6081 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY STE. GENEVIEVE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY STE. GENEVIEVE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN UNION		c. CITY OR TOWN WOMACK	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION WOMACK		e. STREET ADDRESS (If rural, give location) R.R. 0950	

3. NAME OF DECEASED (Type or Print) a. (First) DONALD b. (Middle) GENE c. (Last) CLARK			4. DATE OF DEATH (Month) (Day) (Year) APRIL 6, 1957		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH APRIL 3, 1957		9. AGE (In years last birthday) 3		10. F UNDER 1 YEAR Months 3 F UNDER 1 HR. Hours 3 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) STE GENEVIEVE CO. MO.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME GROVER CLARK		13b. MOTHER'S MAIDEN NAME MONA COOPER		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS GROVER CLARK, WOMACK, MO.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PREMATURE BIRTH					
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		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		20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) 776X	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Russell Basler		23b. ADDRESS Conover St. Farmington Mo.		23c. DATE SIGNED 4/6/57	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4/7/57		24c. NAME OF CEMETERY OR CREMATORY PARKVIEW	
				24d. LOCATION (City, town, or county) (State) FARMINGTON MO.	

DATE REC'D BY LOCAL REG. 4-7-57		REGISTRAR'S SIGNATURE Russell Basler		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MILLER FUNERAL HOME FARMINGTON, MO.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 Not Embalmed, Student Embalmer No.
working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Burl J. Miller
Licensed Embalmer No. 375
P. O. Address Farmington

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.