THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 29 1957

23583
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 794

1. PLACE OF DEATH
a. COUNTY Buchanen
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Joseph — Inside Limits Yes X No
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) State Hosp,No,2 — Length of stay in this place 20 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Buchanen
c. CITY OR TOWN St Joseph — Inside Limits Yes X No
d. STREET ADDRESS State Hosp, (If rural, give location) 34th & Frederick — Reside on Farm Yes No X

3. NAME OF DECEASED (Type or print): First Missie; Middle; Last Clark
St. Joseph Mo.
DATE OF DEATH: Month 7 Day 18 Year 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐
8. DATE OF BIRTH: Dec,17.1882
9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (City and state or country): Elmira Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Nannie Crowley Kansas City Mo (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterioschlerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) generalized Arteriosclerosis — 4 yrs
DUE TO (c) 4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Dementia praecox -Paranoid type In State Hosp,Since 1937
19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7-10-57, to 7-18-57 and last saw her alive on 7-17-57
Death occurred at 1:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. F. Mundy (Degree or title) MD
22b. ADDRESS St Joseph Mo
22c. DATE SIGNED July 18-1957

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7-20-57
23c. NAME OF CEMETERY OR CREMATORY: Prarie Ridge
23d. LOCATION (City, town, or county) (State): Polo Mo.

24. FUNERAL DIRECTOR: John Bram ADDRESS: maysville Mo
25. DATE RECD. BY LOCAL REG.: July 22,1957
26. REGISTRAR'S SIGNATURE: Mrs. Robert Fulton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed John B

Licensed Embalmer No. 393

P. O. Address Maysville

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.