

Health,  
& Welfare  
Public  
Service

S. 300  
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 26 1957

STATE FILE NUMBER 41657

Registration District No. 316 Primary Registration District No. 6074 Registrar's No. 361

1. PLACE OF DEATH a. COUNTY <b>ST. FRANCIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>GEORGIA</b> b. COUNTY <b>FULTON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Desloge</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ATLANTA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb <b>4 mo.</b>	d. STREET ADDRESS (If outside, give location) <b>8100</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>E.</b> Last <b>CLARKE</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT 15 1897</b>		9. AGE (In years last birthday) <b>60</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>29</b> IF UNDER 24 HRS.: Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>LONDON, ENG.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY BRATTLE</b>				14. MOTHER'S MAIDEN NAME <b>JANE DONNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>373-03-6589</b>	17. INFORMANT Address <b>Mr. Albert Kitcherside Berloger Mo</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforated abdominal viscera</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of stomach, intestine liver and colon</b> DUE TO (c) <b>1998</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>Uninvolved arterial sclerosis. Malnutrition</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b> <b>6 months</b> <b>several years</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b></b> Month, Day, Year a. m. <b></b> p. m. <b></b>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>8-29-57</b> to <b>11/14/57</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>11/11/57</b> Death occurred at <b>5:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Paul L. Jones M.D.</b>				22b. ADDRESS <b>Flat River, Mo</b>		22c. DATE SIGNED <b>11-14-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>NOV. 16, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKVIEW</b>		23d. LOCATION (City, town, or county) (State) <b>NEAR FARMINGTON, MO.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Reginald Caldwell and Sons Flat River, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Nov. 14, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Esther Rudloff</b>	

(Licensed Embalmer's Statement on Reverse Side)

89-0

DEC 4 1957

VS JUL 29 1959

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 *R. Caldwell* .....

Licensed Embalmer No. *253*

P. O. Address *Flat River*

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.