

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045323
STATE FILE NUMBER

FILED JAN 13 1958

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 491

300
1-57

1. PLACE OF DEATH a. COUNTY ST. FRANCOIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Reynolds	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. FRANCOIS TOWNSHIP		c. CITY OR TOWN Ellington 0900	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital # 4		d. STREET ADDRESS (If outside, give location) Length of stay in lb 2Y, 10M, 29Day	
3. NAME OF DECEASED (Type or print) First MATTIE Middle WASHINGTON Last CLARK		4. DATE OF DEATH Month Day Year December 22, 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Redford, Missouri
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME Sarah Medcalf	14. NAME OF HUSBAND OR WIFE Luther Clark
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Records State Hospital # 4 Farmington Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral hemorrhage - - - - - DUE TO (b) Cerebral arteriosclerosis - - - - - DUE TO (c) 331x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction			INTERVAL BETWEEN ONSET AND DEATH Abt. 24 hrs. Unknown.
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 .Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 Dec. 21, 1958 to Dec. 22, 1958 and last saw her alive on Dec. 22, 1958 Death occurred at 7:30 A. M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John A. Brennan, M.D.		22b. ADDRESS State Hospital No. 4 Farmington, Missouri	
22c. DATE SIGNED 12-22-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 25, 1958	
23c. NAME OF CEMETERY OR CREMATORY Ellington Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Ellington, Missouri	
24. FUNERAL DIRECTOR ADDRESS Rewitt Funeral Home, Ellington, Mo.		25. DATE RECD. BY LOCAL REG. Jan. 6, 1959	
26. REGISTRAR'S SIGNATURE Esther Kudloff			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Paul H. Dugan* _____

Licensed Embalmer No. *4170*

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.