

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004547

STATE FILE NUMBER

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 226

FILED MAR 9 1959

300
1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph <i>117</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.		Length of stay in lb 50 years	d. STREET ADDRESS (If outside, give location) 2008 Highly Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MEREDITH Middle CLARK Last CLARK			4. DATE OF DEATH Month Feb. Day 26, Year 1959
5. SEX male	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 Feb. 12, 1902
9. AGE (In years, months and days) 57		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (City and state or country) Shennandoah, Iowa
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Frank B. Clark	
13b. MOTHER'S MAIDEN NAME Estella Fewson		14. NAME OF HUSBAND OR WIFE Thelma	
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. 491-10-5108	17. INFORMANT Address Mrs. Thelma Clark, 2008 Highly, St. Joseph, 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) Acute Coronary & Myocardial Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Respiratory Congestion - partial DUE TO (c) respiratory mechanism Paralysis 357X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) Ascending Paralysis (Landry's Type) Several Wks			INTERVAL BETWEEN ONSET AND DEATH 24 hrs several wks
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
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 9-2-49 to 2-26-59 and last saw him alive on 2-26-59 Death occurred at 6:45p. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Robert W. Kieber MD	
22b. ADDRESS St. Joseph, Mo		22c. DATE SIGNED 2-28-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3/2/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph Missouri (State)
24. FUNERAL DIRECTOR Heaton-Bauman ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Mar. 2, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
 Dr. Robert W. Kieber
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

1953

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 *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address... *St. Joseph MO*

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.