

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021269

STATE FILE NUMBER

2845

FILED JUN 24 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2845

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-57  
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1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>KANSAS CITY, MO.</u> TOWN <u>KANSAS CITY, MO.</u>		c. CITY OR TOWN <u>KANSAS CITY</u> 188 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. St. Joseph's</u>		d. STREET ADDRESS (If outside, give location) <u>3218 E. 10th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in 1b <u>46 yrs</u>			

3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>W.</u> Last <u>Clark</u>			4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>59</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1913</u>	9. AGE (In years last birthday) <u>46</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN, MASONRY, DATA FORMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL PLANT</u>	11. BIRTHPLACE (City and state of country) <u>BUCKNER, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOHN CLARK</u>	13b. MOTHER'S MAIDEN NAME <u>LEUENA PATTERSON</u>	14. NAME OF HUSBAND OR WIFE <u>MAMIE CLARK</u>
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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) <u>YES U.S. II</u>	16. SOCIAL SECURITY NO. <u>499-10-0599</u>	17. INFORMANT Address <u>MAMIE CLARK, 3218 E. 10th St. K.C. Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary heart disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u> <u>3 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

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 _____ o.m. _____ p.m. Month, Day, Year _____	

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
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21. I attended the deceased from May 1956 to 6/9/59 and last saw him alive on 6/9/59  
Death occurred at 11:57 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. B. Mc Cunniff M.D.</u>	22b. ADDRESS <u>836 Argyle Bldg</u>	22c. DATE SIGNED <u>6/10/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JUNE 12, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. St. Mary's Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, MO.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>GEO. C. CARSON &amp; SONS, INDP. MO</u>	25. DATE RECD. BY LOCAL REG. <u>6-11-59</u>	26. REGISTRAR'S SIGNATURE <u>Nevar Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.  
W. B. Mc Cunniff

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

JUL 7 1959 6961 2 700

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. Kenneth Patterson*

Licensed Embalmer No. *4697*

P. O. Address *Indus 722*

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.