

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031977

FILED VS SEP 21 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 944A STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in lb 35 years		c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2111 West Chestnut			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2111 West Chestnut		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle BOYD Last CLARK				4. DATE OF DEATH Month Sept. Day 5, 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 Aug. 28-1894	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months 0 Days 8	IF UNDER 24 HR Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter & Baker--Frisco RR-Holsum Bakery Yellville, Ark.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) U. S. A.		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME Charley Clark			13b. MOTHER'S MAIDEN NAME Sallie (?)			14. NAME OF HUSBAND OR WIFE Bessie M. Sims		
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. 702 07 4560		17. INFORMANT Mrs. Bessie M. Clark, Springfield, Ark.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arterio Sclerotic DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Tuberculosis 1958					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.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		
21. I attended the deceased from 9-5-59 to 9-5-59 and last saw her/him alive on Not seen Alive Death occurred at 3:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Signature or Title) [Signature]				22b. ADDRESS [Address]		22c. DATE SIGNED 9-11-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/8/1959	23c. NAME OF CEMETERY OR CREMATORY Flood Cemetery		23d. LOCATION (City, town, or county) (State) Highlandville, Missouri			
24. FUNERAL DIRECTOR [Signature] ADDRESS Clever, Mo.			25. DATE RECD. BY LOCAL REG. 9-15-59		26. REGISTRAR'S SIGNATURE [Signature]			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 7 2

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. Dean Harris

Licensed Embalmer No. 4390

P. O. Address Claver, 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.