

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS SEP 16 1959**

**59-034999**

STATE FILE NUMBER

Registration District No. 366 Primary Registration District No. \_\_\_\_\_ Registrar's No. 70

EMENDED

1. PLACE OF DEATH a. COUNTY <b>Washington</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Washington</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bellevue</b>		Length of stay in 1b <b>38 yrs.</b>		c. CITY OR TOWN <b>Bellevue</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rd. 21, 2 mi. N. of Caledonia</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Rd. 21, 2 mi. N of Caledonia</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>FREDERICK HENRY CLARKE</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>6</b> Year <b>1959</b>				
5. SEX <b>male</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>Aug. 3 1984</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (City and state or country) <b>Troy Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Sylvester Clarke</b>			13b. MOTHER'S MAIDEN NAME <b>Lucille Jacobs</b>		14. NAME OF HUSBAND OR WIFE <b>Julia Belle Clarke</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>no</b>		17. INFORMANT Address <b>Mrs. Ruth Lucas, Caledonia 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>Carcinomatosis, general</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 year.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Adenocarcinoma of prostate.</b>							<b>5 year.</b>	
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus.</b>						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 <b>12-5-55</b> to <b>9-6-59</b> and last saw <sup>her</sup> him alive on <b>9-24-57</b> Death occurred at <b>9.30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Ben M. Bull, M.D.</b>				22b. ADDRESS <b>Ironton, Mo.</b>		22c. DATE SIGNED <b>9-8-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>9-9-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arcadia Valley Memorial Park Ironton Mo.</b>		23d. LOCATION (City, town, or county) <b>Ironton Mo.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>White Funeral Home, Ironton Mo.</b> <b>Ansel J. White</b>			25. DATE RECD. BY LOCAL REG. <b>9/12/59</b>		26. REGISTRAR'S SIGNATURE <b>Herbert Euclid</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 *Annelj White*

Licensed Embalmer No. 3012

P. O. Address *Boston Mass*

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.