

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-048856

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 237 Primary Registration District No. 5859 Registrar's No. 277 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 24 1963

VS 300	DATE AMENDED
Rev. 4/59	
1 <u>0740</u>	
2 <u>0740</u>	
3 <u>1</u>	
4 <u>0</u>	
5 <u>0</u>	
6	
7 <u>0</u>	
8 <u>2</u>	
9 <u>451X</u>	
10	
11	
12 <u>90-0</u>	
13 <u>1-0</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Monroe Township</u>		Length of stay in 1b <u>2 yrs.</u>	c. CITY OR TOWN <u>Skidmore</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 1/2 Mi. East-Skidmore</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 1/2 mi. East- Skidmore</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Callie Jackson Clark</u>			4. DATE OF DEATH Month Day Year <u>Dec. 13 1963</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/8/1905</u>
9. AGE (last birthday) <u>58</u>		IF UNDER 1 YEAR Months Days <u>8 5</u>	IF UNDER 24 HR Hours Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Partner</u>	11. BIRTHPLACE (City and state or country) <u>Cedar County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>B. L. Clark</u>	
13b. MOTHER'S MAIDEN NAME <u>Laury Long</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>Mrs. Flavin Hall Skidmore, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arterio Sclerosis, Chronic</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary insufficiency</u>			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.) <u> </u>	
20c. TIME OF INJURY Hour a.m. p.m. <u> </u>	Month, Day, Year <u> </u>	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.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u>
20g. STATE <u> </u>		21. I attended the deceased from <u>April 62</u> to <u>8/16/63</u> and last saw her alive on <u>8/16/63</u> . Death occurred at <u> </u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>Maryville, Mo.</u>	22c. DATE SIGNED <u>12/13/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>12/13/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Home Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Tarkio Mo/</u>
24. FUNERAL DIRECTOR ADDRESS <u>Davis Funeral Home Tarkio, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-14-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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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 John M. [Signature]
Licensed Embalmer No. 4869
P. O. Address Tarkio, 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.