WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VIAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Montgomery

Township or Village Montgomery or City (NO. St.: Ward)

Registration District No. 592 File No. 19558

Primary Registration District No. 4350 Registered No. 16

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Emerson Clark

PERSONAL AND STATISTICAL PARTICULARS

SEX M

COLOR OR RACE Colored

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Feb (Month) 4 (Day) 1885 (Year)

AGE 30 yrs. 4 mos. 23 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Lafor 83A
(b) General nature of industry, business, or establishment in which employed (or employer) 95B 111B

BIRTHPLACE (City or town, State or foreign country) Middletown Mo

PARENTS
NAME OF FATHER Geo Clark
BIRTHPLACE OF FATHER (City or town, State or foreign country) Middletown Mo
MAIDEN NAME OF MOTHER Addie Spotsis
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Callaway Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Emerson Clark

(ADDRESS) Montgomery City Mo

Filed June 30 1915 E. W. Linsley REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June (Month) 28 (Day) 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 16, 1915, to June 28, 1915, that I last saw him alive on June 26, 1915, and that death occurred, on the date stated above, at 3 45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema
acute cardiac dilitation
~~Fatal~~ Pulm. tuberculosis

(Duration) 6 yrs. — mos. — ds.

Contributory (SECONDARY) see above

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Waldin E. Mann M. D.

June 28 1915 (Address) Montgomery City, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Montgomery City Cemetery

DATE OF BURIAL 6/30 1915

UNDERTAKER C W Hopkins

ADDRESS Montgomery Mo

M

PLACE OF [illegible]TH

County.....

Township .....
or
Village.....
or
City .....(NO. ..... St.; ..... Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191...., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.