V. S. No. 2. A

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

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.

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

MARGIN RESERVED FOR BINDING

1 PLACE OF DEATH

County: Stone

Township: ~~Lincoln~~ Pierce — Registration District No. 842 — File No. 15271

Village: — Primary Registration District No. 6104 — Registered No.

City: (NO. , St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME: Elton Earl Clark

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	

6 DATE OF BIRTH: Feb 3, 1919 (Month) (Day) (Year)

7 AGE: 1 yrs. 1 mos. ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION: Trade, profession, or particular kind of work

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

BIRTHPLACE (City or town, State or foreign country): Stone Co Mo

10 NAME OF FATHER: W. S. Clark

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Barry Co

12 MAIDEN NAME OF MOTHER: Pearl Carney

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Stone Co

THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE

Informant: W. S. Clark

(Address): Crane Mo

Filed 3-14, 1920. Rue Kelly, Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: ~~Feb~~ Mch 3, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 22, 1920, to Mch 3, 1920 that I last saw him alive on Mch 2, 1920, and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

114

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary): Influenza

(Duration) yrs. mos. 14 ds.

(Signed) H. L. Kerr, M. D.

Mar 4, 1920 (Address) Kerr.

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Nolan cemetery — DATE OF BURIAL: 3 4, 1920

20 UNDERTAKER: W. E. Nolan — ADDRESS: Crane Mo

V. S. No. 2. A

MARGIN RESERVED FOR BINDING

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

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MISSOURI STATE BOARD OF HEAL

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ...St.;.....Ward)

[If death occurre hospital or instit give its NAME i of street and num

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191...
(Month) (Day) (Y

17 I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 191.

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

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed).....M

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transi or Recent Residents)

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

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

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191
20 UNDERTAKER	**ADDRESS**