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

1. PLACE OF DEATH
County: Miller
Township: Equalitis
City: (No. ..... St. ..... Ward)
Registration District No.: 564
Primary Registration District No.: 5758
File No.: V21999 (B)
Registered No.:

2. FULL NAME: Mary J. Clark
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Alex Clark

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 17-1868

7. AGE: Years 59 | Months 2 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mother Co MO

PARENTS
10. NAME OF FATHER: Geo Nelson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Det Know
12. MAIDEN NAME OF MOTHER: Elizabeth Rowlon
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Det Know

14. INFORMANT: Alex Clark
(Address): Tuscumbia

15. FILED 7/21 1927 D T Rowes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-19 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-19, 1927, to 7-19, 1927, that I last saw her alive on 7-19, 1927, and that death occurred, on the date stated above, at 1:00 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Investigation
11900 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 1 Hour
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ✓
0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) D T Rowes M.D
, 19 (Address) Tuscumbia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Zion
DATE OF BURIAL: 7 21 1927

20. UNDERTAKER: W. A. Phillips
ADDRESS: Eldon

NOTE: 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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Miller
Township: Equality
City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 564
Primary Registration District No. 5758

File No. .....
Registered No. .....

2. FULL NAME: Mary J. Clark

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f
4. COLOR OR RACE: w
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): m

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE: YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT: A Reed
(Address): Troy Ohio

15. FILED ....., 19 ..... D H Kaiser
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 19 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute indigestion
due to eating of
fried chicken
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) D H Kaiser M. D.
, 19 (Address) Tiffin Ohio

*State the DISEASE CAUSING ~~Death, or in deaths~~ from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL: 7/30 1927

20. UNDERTAKER: A J Philips | ADDRESS: Elida Ohio

SUPPLEMENTARY

B.— ... should be stated B... AGE should be stated ... "CI ... should state ... in plain t... so that it may be properly classified. Exact statement of C... is very important.

... SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-21