JAN 1 1928

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

Do not use this space.

W.H. 37516

1. PLACE OF DEATH
County Macon
Township ~~Hudson~~
City Macon (No. ..... St. ..... Ward)

Registration District No. 533
Primary Registration District No. 3027

File No. .....
Registered No. 109

2. FULL NAME Andy H. 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 Male
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 X X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 21. 1873

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
54	4	28	

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

9. BIRTHPLACE (CITY OR TOWN) Green Top
(STATE OR COUNTRY) Mo

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

14. INFORMANT Mrs. Andy Clark
(Address) Macon Mo

15. FILED 12/29, 1927 Mrs Luke Hunkler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/19 1927

17. I HEREBY CERTIFY, That I attended deceased from 10 Dec, 1927, to Dec 19, 1927, that I last saw him alive on Dec 19, 1927, and that death occurred, on the date stated above, at 5 25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Typhoid fever

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTOR (SECONDARY) 1A

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED At home
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? M DATE OF ✓
WAS THERE AN AUTOPSY? M
WHAT TEST CONFIRMED DIAGNOSIS? Clinic
(Signed) W H Miller, M. D
12/20, 1927 (Address) Macon Mo

*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 Chappel Hill Cem
DATE OF BURIAL 12/21 1927

20. UNDERTAKER Albert Skinner
ADDRESS Macon Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Macon — Registration District No. 533 — File No.

Township — Primary Registration District No. 3027 — Registered No. 109

City Macon (No. , St. Ward)

2. FULL NAME Andy H. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	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) Don't Know

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Don't Know.

14. INFORMANT
(Address)

15. FILED 2/1 1928 Mrs Luke Hunkler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/19 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:

(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) , M. D
, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGIS HALL NOT RECEIVE A FEE F CEI ES AS PP BY W