

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

Do not use this space.

15937
~~15937~~

Roberts

1. PLACE OF DEATH *Arboret*
 County.....
 Township.....
 City.....
 Registration District No. *896*
 Primary Registration District No. *45712*
 File No.....
 Registered No. *16*
 St..... Ward.....

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

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 *Mary Clark*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan. 2, 1850*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 | 2 | 22

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr. 7 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Apr 4 1928* to *Apr 4 1928* that I last saw him alive on *Apr 4 1928*, and that death occurred, on the date stated above, at *7:30 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy

82A
 CONTRIBUTORY (SECONDARY) *7401*

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

10. NAME OF FATHER *Samuel Clark*

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
 (STATE OR COUNTRY) *Indiana*

12. MAIDEN NAME OF MOTHER *Mrs Brown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
 (STATE OR COUNTRY) *Indiana*

14. INFORMANT (Address) *Blackwood Ave Mrs. Isaac Ault*

15. FILED *Apr 15 28* *J. H. Bruce* REGISTRAR

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH?.....

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *marshfield* DATE OF BURIAL *4/15 1928*

20. UNDERTAKER *H. J. M. Graham* ADDRESS *marshfield*

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed) *W. G. Roberts* M. D.
4/5/28 (Address) *Marshfield 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.

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.

SUN 5

