

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

Do not use this space.

16157

1. PLACE OF DEATH

County Buchanan
Township.....
City St. Joseph,

Registration District No. 85
Primary Registration District No. 1001
(No. Missouri Methodist Hospital)

File No.....
Registered No. 546
St. Ward)

2. FULL NAME Mary Clark, Road

(a) Residence. No. 1 N. So. of City, Sparta 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. 3 mos. 14 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) Divorced,

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 20, 1882

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>45</u>	<u>7</u>	<u>11</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Buchanan County,
(STATE OR COUNTRY) Missouri,

10. NAME OF FATHER Commodore P. Armstrong

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Tennessee,

12. MAIDEN NAME OF MOTHER Margaret McInturn
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Platte Co.,
(STATE OR COUNTRY) Missouri,

14. INFORMANT Mrs. Margaret Glan
Address Wallace Mo.

15. FILED 2 1928 REGISTRAR John G. Webb

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1st 1928

17. I HEREBY CERTIFY That I attended deceased from April 1st 1928 to May 1st 1928 and that I last saw her alive on May 1st 1928, and that death occurred, on the date stated above, at 3p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

35 Embolism Pulmonary Artery
130 B / 111 B / (duration) yrs. mos. 39 days
CONTRIBUTORY (SECONDARY) Saphinglectomy / Cophurectomy (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: Buchanan County Infirmary

DID AN OPERATION PRECEDE DEATH? yes DATE OF April 26 1928

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A. E. Holley M. D.

5/7, 1928 (Address) 822 Edmond St. St. Joseph 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 DATE OF BURIAL

Mount Mora Cemetery May 2nd. 1928

20. UNDERTAKER ADDRESS 319 S. 10 St.

Heaton, Regal, Bowman
by J. M. Steele Burial Home

100

100

100

100

100

100

100

100

100

100

**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 Buchanan

Registration District No. 86

File No.

Township

Primary Registration District No. 1001

Registered No. 346

City St. Joseph (No.) St. Ward)

2. FULL NAME

Mary 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Div.

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)

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 (Address)

15. FILED 5/2/28 John G. Pitt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1 - 1928

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:

Emphysema Pulmonary
Chronic
Exacerbated Salpingitis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Salpingectomy & Oophorectomy
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? Yes D. No.

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? 992

(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

20. UNDERTAKER ADDRESS

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

