

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

Do not use this space.

9602

1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township _____ Primary Registration District No. 1001
 City St. Joseph (No. 3006 No. 8th. St. St. _____ Ward)

2. FULL NAME John Clark
 (a) Residence. No. 3006 North 8th St., _____ Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. 307
 St. _____ Ward)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 1--1843

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	85	7	4	

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

9. BIRTHPLACE (CITY OR TOWN) New Lancaster
 (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Jacob Clark

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Unknown

14. INFORMANT Mrs. Laura E. Marvin
 Address 3006 N. 8th St

15. FILED MAR 6 1929
 19 _____
John E. Galt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 5th 19 29

17. I HEREBY CERTIFY, That I attended deceased from Mar. 4, 1929, to Mar 5, 1929 that I last saw him alive on Mar 5, 1929, and that death occurred, on the date stated above, at 12:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Solar Pneumonia
10R
106R / 101W
 (duration) _____ yrs. mos. 2 ds.
 CONTRIBUTORY acute cold
 (SECONDARY) (duration) _____ yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) P. H. Beebe M. D.
Mar. 6, 1929 (Address) P. H. Beebe

*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 Leon, Iowa. DATE OF BURIAL Mar, 8, 19 29

20. UNDERTAKER St. Mirschoffer ADDRESS 1302 Parnon

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.

1929
 1
 2
 2
 31

