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

Do not use this space.

35188

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. St. Lukes Hosp St. ..... Ward)

File No. ..... Registered No. 9923

2. FULL NAME Cummings C. Clark

(a) Residence. No. Webster Groves St., 12 Ward. Webster Groves Mo
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 5 - 1901

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	28	0	3	

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

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9. BIRTHPLACE (CITY OR TOWN) Little Rock
(STATE OR COUNTRY) Ark.

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PARENTS

10. NAME OF FATHER Allen W. Clark

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

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12. MAIDEN NAME OF MOTHER Florence Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) St. Louis, Mo.

14. INFORMANT Allen W. Clark
(Address) 3729 Washington

15. FILED ..... 19 29 Mark Starkcoff REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct - 8 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 - 1929, to Oct - 8 - 1929 that I last saw him alive on Oct - 7 - 1929 and that death occurred, on the date stated above, at 8 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia - left lower & right mid lobes
108 Type II
36 (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (SECONDARY) Pneumoca septicemia
Type - II (duration) ..... yrs. ..... mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at home
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Xray & blood cultures

(Signed) H. A. Goodrich, M. D.
10/9, 1929 (Address) Webster Groves

*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
Bellefontaine	10-10- 1929
20. UNDERTAKER	**ADDRESS**
Wagoner	3621 Olive

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.