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

Do not use this space.

1232

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1002 — Registered No. 223
City K. C. Mo (No. St Joseph Hosp St. Ward)

2. FULL NAME Mrs F. B. Clark
(a) Residence. No. Lawson Mo 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: F M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Frank Clark

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Apl 2 1900

7. AGE: Years 29 — Months 9 — Days 12 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife 1398 179
(b) General nature of industry, business, or establishment in which employed (or employer): 36
(c) Name of employer

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9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: E Sisk
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Maria Weffer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ky

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14. INFORMANT: E. Sisk
(Address): Lawson

15. FILED Jan 17 1930 M. M. Crowe Registrar Assn

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan-14 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Jan 14, 1930, that I last saw her alive on Jan 14, 1930, and that death occurred, on the date stated above, at 8:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General sepsis from severe pelvic peritonitis and pelvic abscess (duration) yrs. 2 mos. ds.

CONTRIBUTORY (SECONDARY): Probably salpingitis (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Lawson Mo.
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 1-13-30
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Exploratory laparotomy
(Signed) Eugene P. Hamilton, M. D.
1-14, 1930 (Address) 602 Argyle K.C. 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: Lawson Mo — DATE OF BURIAL: Jan 16 19

20. UNDERTAKER: J M Ward — ADDRESS: Lawson

N. B.—Every item of information should be carefully supplied. ... statement of OCCUPATION is very important.
CAUSE OF DEATH in plain terms, so that it may be properly classified ... should state

MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County ..... Registration District No. 399 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 223

City K. City (No. ....., ... St. ..... Ward)

2. FULL NAME Mrs F. B. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	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)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED Jan 17 1930 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1930

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:
General Sepsis from severe pelvic peritonitis and pelvic abscess
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Probably salpingitis or Non-puperal (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

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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.

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

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