

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

Do not use this space.

25768

1. PLACE OF DEATH

County Adair Registration District No. 4
Township _____ Primary Registration District No. 3001
City Kirksville (No. _____) St. _____ Ward _____

File No. _____
Registered No. 131

2. FULL NAME

Eveline Amelia Clark
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1, 1838

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
92 3 11

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) Mount Pleasant
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Jonathan Miller

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

12. MAIDEN NAME OF MOTHER Polly Stone

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

14. INFORMANT Nellie Lacey
(Address) Kirksville Mo.

15. FILED 7/16, 1930 Mrs C. W. Becker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 12 1930

17. I HEREBY CERTIFY, That I attended deceased from 8-25, 1930, to Aug 10, 1930 that I last saw her alive on Aug 10, 1930 and that death occurred, on the date stated above, at 9:30 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Senility
95A
162 (duration) yrs. mos. ds.
CONTRIBUTORY auricular fibrillation
(SECONDARY) (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRASTED IF NOT AT PLACE OF DEATH 9019

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Roostickler M. D.
, 19 (Address) Kirksville 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 Highland Park DATE OF BURIAL Aug 12 1930

20. UNDERTAKER Summer Bon ADDRESS Kirksville

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 SEP 20 1930

