

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

Do not use this space

396765251

1. PLACE OF DEATH  
 County Jackson Registration District No. ....  
 Township Kaw Primary Registration District No. ....  
 City Kansas City (No. 3923 St. John Avenue St. .... Ward)

2. FULL NAME Edwin F. Clarkson  
 (a) Residence No. 3923 St. John Avenue St. 10 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. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Stewart Clarkson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 30, 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
63 4 0

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Grading Contractor  
 (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) Missouri

10. NAME OF FATHER G. G. Clarkson

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

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT Mrs. Elizabeth Stewart Clarkson  
 (Address) 3923 St. John Ave

15. FILED 12-31-30 m.m. Crowe  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-30 1930

17. I HEREBY CERTIFY, That I attended deceased from .....  
 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:  
Coronary Sclerosis  
94B

(duration) yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) 91B  
 (duration) yrs..... mos..... ds.

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

0 DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? History, Inspection  
 (Signed) Harley M. Abel, M. D.

17 30, 19 30 (Address) Deputy Coroner

\*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  
Elmwood Cemetery Jan-3 1930

20. UNDERTAKER ADDRESS 3235  
Stine + McClure Wicham Plaza

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.

