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.

APR 17 1936

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

Do not use this space.

9787

1. PLACE OF DEATH
County: Clay — Registration District No.: 198 — File No.:
Township: Fishing River — Primary Registration District No.: 3011 — Registered No.:
City: Excelsior Springs, Mo (No. (Veterans Administration Facility) St. 3d Ward)

2. FULL NAME: WHITE, Clark Hudson

(a) Residence, No. Veterans Adm. Facility, St. Excelsior Springs, Mo. R#2, Liberty, Mo.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. 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): Effie White

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 1896 (mo.& da. unknown)

7. AGE — Years: 39 — Months: ? — Days: ? — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Farm
10. Date deceased last worked at this occupation (month and year): Unknown
11. Total time (years) spent in this occupation: Unknown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Belton, Mo.

FATHER
13. NAME: James H. White
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Virginia

MOTHER
15. MAIDEN NAME: Missouri Reed
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT (ADDRESS): Hospital Records

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Liberty, Mo. DATE: 3-22-1936

19. UNDERTAKER (ADDRESS): Prather Und. Co. Excelsior Springs Mo.

20. FILED 3-21-1936 Mrs. Red McCracken Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): March 21, 1936

22. I HEREBY CERTIFY, That I attended deceased from 3-19-36, 19..., to 3-21, 1936
I last saw him alive on 3-21-36, 19..... Death is said to have occurred on the date stated above, at 5 PM m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	
Other contributory causes of importance: --	

Name of operation: -- Date of:
What test confirmed diagnosis? Exam. & Obs. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? -- Date of injury -- , 19....
Where did injury occur? --
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
--
Manner of injury: --
Nature of injury: --

24. Was disease or injury in any way related to occupation of deceased?
If so, specify: --

(Signed) [illegible] M. D.
(Address) Veterans Administration Facility
Excelsior Springs, Mo.