

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.

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

Do not use this space.

MAY 22 1939

1. PLACE OF DEATH  
County Pike Registration District No. 684  
Township Duane Primary Registration District No. 4408  
City Bowling Green (No. ....) St. .... Ward)  
2. FULL NAME Emmet Leon 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.

File No. 15811  
Registered No. 11

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 27 - 1935

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
X 2 14

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bowling Green Mo.

13. NAME Charles Clark

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Masonville Mo.

15. MAIDEN NAME Ethel Benjamin

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison Mo.

17. INFORMANT (ADDRESS) Charles Clark

18. BURIAL, CREMATION, OR REMOVAL PLACE Bowling Green Cemetery 3 - 19 - 1939

19. UNDERTAKER (ADDRESS) Thomas Bluehead

20. FILED 5-1-39 W. B. Wilcox Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-14-39 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

I last saw him alive on MARCH 10, 1939 Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

BRONCHOPNEUMONIA 3-1-39  
Other contributory causes of importance:

Name of operation none Date of .....  
What test confirmed diagnosis? none 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? no  
If so, specify .....

(Signed) W. B. Wilcox M. D.  
(Address) Bowling Green Mo.

1097a

RECEIVED

District Health Officer No. 10

District File Number 10-39-881

Date Filed MAY 3 1939

USE OF DEVELOPMENTAL FORMS 2014  
A. B. — Each item of information should be

should be signed FAXCJL

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

15811  
Do not use this space.

Do not use this space.

1. PLACE OF DEATH  
 (a) County Pike Registration District No. 684  
 (b) Township Rolling Green Primary Registration District No. 4408  
 (c) City Rolling Green (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Emmet Leon Clark  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) \_\_\_\_\_

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.
		<u>2</u>	<u>14</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

FATHER

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

MOTHER

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-14, 1997

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:  
Broncho Pneumonia  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:  
no complications  
no pneumonia  
no whooping cough  
1070

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) W. B. Wilcofen, M. D.  
 (Address) Rolling Green Mo

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is also important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Local Registrar.

