

FILED AUG 14 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

24093
2703

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Trinity Withern Hospital, K.C. Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) 4 Years.

8. (a) PRENT FULL NAME T. Clark Mc Clintock, 745

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mattie May Mc Clintock, Deceased, 1935. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 20th, 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67-4-14 hr. _____ min.

9. Birthplace Millersburg, Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Groceryman

11. Industry or business _____

12. Name Joshue Corbin Mc Clintock

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Cynthia Jane Griffith,

15. Birthplace Kentucky.
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Frances Elizabeth McClintock
(b) Address 3725 Baltimore, K. C. Mo.

17. (a) Burial (b) Date thereof 7-6-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery.

18. (a) Signature of funeral director Mrs. C. L. Forster,

(b) Address 918 Brooklyn Avenue, K.C. Mo.

19. (a) July 6, 1940 (b) M. M. Crome
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Missouri.
(If outside city or town limits, write "RURAL")
(d) Street No. 2940 Woodland, K. C. Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4th,
year 1940 hour _____ minute _____ P:M.

21. I hereby certify that I attended the deceased from July 2,
1940, to July 4, 1940
that I last saw him alive on July 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
1- Esophageal Neurostoma
2- Splenic hyperplasia
Due to 3- Secondary anemia
4- Generalized arteriosclerosis
Due to 5- Peptic ulcers
Other conditions 12/10
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature M. M. Crome (M. D. or other)
Address Trinity Hospital Date signed 7/6-1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Office *Wise*
Ph: Ves 3434
1. 288 530

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Registered Apprentice No.

working under my personal supervision.

Signed

L. H. Wise

Licensed Embalmer No.

2570

P. O. Address

120 W

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **24093**
Registrar's No. **2703**

Registration District No. **399**

Primary Registration District No. **1002**

WHITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Jackson**
 (If outside city or town limits, write "RURAL" and name of township)
 Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (c) Length of stay: In hospital or institution.
 In this community _____ (Specify whether year, months or days)

3. (a) PRINT FULL NAME: **Thomas Clark McClintock**
3. (b) If veteran, name war: _____
3. (c) Social Security No.: _____

4. Sex: **m**
5. Color or race: **w**
6. (a) Single, widowed, married, divorced: **wid**
6. (b) Name of husband or wife: _____
6. (c) Age of husband, or wife, if alive: _____ year

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

8. AGE:
 Years: **67** Months: **4** Days: **14**
 If less than one day: _____ hr. _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation: _____

11. Industry or business: _____

FATHER { **12. Name:** _____

13. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

MOTHER { **14. Maiden name:** _____

15. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant: _____
(b) Address: _____

17. (a) _____ (b) Date thereof: _____ (Month) _____ (Day) _____ (Year)
(c) Place: burial or cremation: _____

18. (a) Signature of funeral director: _____
(b) Address: _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

20. DATE OF DEATH: Month **July** day **7** year **1940** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): _____
(b) Date of occurrence: _____
(c) Where did injury occur?: _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature: _____ (D. or other)
Address: _____ Date signed _____

SUPPLEMENTAL

Duration

PHYSICIAN

 Underline the cause to which death should be charged statistically.

