

Registration District No. 570 Primary Registration District No. 3004 Registrar's No. 69

1. PLACE OF DEATH Bates  
(a) County Butler Missouri  
(b) City or town Butler Missouri  
(c) Name of hospital or institution 909 North Water Street  
(d) Length of stay: In hospital or institution 23 years  
In this community 23 years

3. (a) PRINT FULL NAME Audly B. Clark  
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Cora Clark 6. (c) Age of husband or wife if alive 50 years  
7. Birth date of deceased May 17th-1880

8. AGE: Years 60 Months 3 Days 14 If less than one day hr. min.

9. Birthplace Grundy Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business  
12. Name James Clark  
13. Birthplace Missouri  
14. Maiden name Argaret White  
15. Birthplace Kentucky

16. (a) Informant Cora Clark  
(b) Address 909 N. Water, Butler Mo.

17. (a) burial (b) Date thereof Sept 3, 1940  
(c) Place: burial or cremation Oakhill, Butler Mo.

18. (a) Signature of funeral director Booth Funeral Home  
(b) Address Butler Missouri

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State 0 Missouri (b) County Bates  
(c) City or town Butler Mo.  
(d) Street No. 909 N Water, Butler Mo.  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 31  
year 1940 hour 9 minute 45PM M.

21. I hereby certify that I attended the deceased from Aug 26  
1940 to Aug 31 1940  
that I last saw him alive on Aug 28 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Nephritis  
Duration 1 week

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?  
53 While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) !  
Address Butler Mo. Date signed 9-3-40

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

MOTHER FATHER

120

RECEIVED  
District Health Officer No. 7,  
District File Number 9-40-1340  
Date Filed 9-13-40

**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.....

myself

Registered Apprentice No.....

working under my personal supervision.

Signed

*John H. Underwood*

Licensed Embalmer No. 3585

P. O. Address Butler Missouri

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

State File No. **27875-**

Registration District No. **20**

Primary Registration District No. **3004**

Registrar's No. \_\_\_\_\_

R

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

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

**3. (a) PRINT FULL NAME** **Clark Audley B. Park**  
**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** **m**  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband, or wife, if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

**8. AGE:** Years **60** Months **3** 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** \_\_\_\_\_

**12. Name** \_\_\_\_\_

**13. Birthplace** \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

**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)  
 (Burial, cremation, or removal)

**(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 **8** day **31** year \_\_\_\_\_ 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 **Acute nephritis**

Due to **Dental caries**

Due to **N. M. P. II**

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?** \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

**(e) Means of injury** \_\_\_\_\_

**23. Signature** \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

**Address** \_\_\_\_\_ **Date signed** \_\_\_\_\_

SUPPLEMENTAL CERTIFICATE

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27875-**

Registrar's No. **69**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **20**

Primary Registration District No. **3004**

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

1. PLACE OF DEATH:

(a) County **Bates**  
(b) City or town **Butler**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME **Audley B. Clark**

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 **m**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years **60** Months **3** Days **14** If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

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)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **Oct 5 1940** (b) **Tina L. Culver**  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: month **aug** day **31**  
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 \_\_\_\_\_

Duration

PHYSICIAN

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) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature **A. J. Woodbridge** (M. D. or other) \_\_\_\_\_

Address **Butler Mo** Date signed \_\_\_\_\_

SUPPLEMENTARY