

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.

DEC 17 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39419

Registration District No. 649

Primary Registration District No. 6288

Registrar's No.

1. PLACE OF DEATH:
 (a) County Ozark
 (b) City or town Nottingham, Mo.
 (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 6mo. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Ozark
 (c) City or town Nottingham Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Mary E. Clark
 3. (b) If veteran, name war _____
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov. day 6
 year 1940 hour 8 minute 30 P. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Joe Clark
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased undrawn
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 1, 1940, to Nov 21, 1940
 that I last saw her alive on Nov 2, 1940
 and that death occurred on the date and hour stated above,
 Immediate cause of death Blood Poison Duration _____
cause from infected toe
she was an invalid
 Due to with disease of old age

8. AGE: Years 78 Months _____ Days _____
 If less than one day _____ hr. _____ min.

Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name M. T. Winn
 18. Birthplace Ind.
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Unknown
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Bob Kyle
 (b) Address Nottingham, Missouri

17. (a) Burial (b) Date thereof 11-9-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Gardner

18. (a) Signature of funeral director Clinkingbeard Funeral Home
 (b) Address Ava, Missouri

19. (a) Dec 1-1940 (b) Hattie B. Davis
 (Date received local registrar) (Registrar's signature)

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?
581 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature J. H. Small (M. D. or other) _____
 Address Lutie mo. Date signed Nov 26

PHYSICIAN

 Underline the cause to which death should be charged statistically.

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RECEIVED

District Health Office No. 6,

District File Number 1246-3045

Date Filed DEC 16 1940

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 H. B. Hutchinson

Licensed Embalmer No. 3431

P. O. Address.....

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. 39419

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 649

Primary Registration District No. 6288

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town Wattsonville T.P.
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Mary E. Clark

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive 37 years

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

8. AGE:

Years 78

Months _____

Days _____

If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 11 day 6 year 1906 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw h. _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Blood poison
cause from infected toe

She was an invalid with disease of ear
Due to age

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) (e) Means of injury _____

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

SUPPLEMENTAL

S-39419 1940