DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41642

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 5035

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 917 Central
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 24 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 917 Central
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME CLARENCE D. RABER

3. (b) If veteran, name war No

3. (c) Social Security No. ---

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Alice Raber

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased May 17, 1865 (Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 13 If less than one day hr. min.

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

10. Usual occupation None-retired 10 years

11. Industry or business

FATHER
12. Name Lewis Raber
13. Birthplace No Record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace No Record (City, town, or county) (State or foreign country)

16. (a) Informant Leslie Raber
(b) Address 3007 McGee

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/41 (Month) (Day) (Year)
(c) Place: burial or cremation Lawrence, Kansas

18. (a) Signature of funeral director Quirk & Vohin Co.
(b) Address K. C. Mo.

19. (a) 12-31-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 30 year 40 hour 9 minute A. M.

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

Immediate cause of death Arteriosclerotic heart disease. Bronchopneumonia

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy See above

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

23. Signature [signature] (M. D. or other) 12/31/80
Address [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.