

No. 2  
1-13-40  
17-39  
X23159

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

1843

State File No. \_\_\_\_\_

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 73

1. PLACE OF DEATH:

(a) County BUCHANAN  
(b) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
ST. JOSEPH HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution A few days  
(Specify whether years, months or days)  
In this community 20 yrs. Plus

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BUCHANAN  
(c) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL")  
(d) Street No. NO FACTS  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME WILLIAM CLARK

3. (b) If veteran, SS. 491-10-6904 name war no  
3. (c) Social Security No. (Kansanover)

4. Sex m 5. Color or race negro 6. (a) Single, widowed, married, divorced 9  
6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Sept 7 1885  
(Month) (Day) (Year)

8. AGE: 55 years Months 4 Days 8  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Kansas City Mo. 8  
(City, town, or county) (State or foreign country)

10. Usual occupation labor

11. Industry or business none

12. Name Kansanover

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

14. Maiden name unknown

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

16. (a) Informant Social Welfare Board

(b) Address St. Joseph Mo.

17. (a) burial (b) Date thereof 1-21-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Randy Doo Mathray  
(b) Address 1602 West 1st St.

19. (a) Jan. 20, 1941 (b) (Signature)  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15  
year 1941 hour 12 minute 40 P.M.

21. I hereby certify that I attended the deceased from Jan 2, 1941 to 1-15, 1941  
that I last saw him alive on 1-15, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Cardio-vascular Renal Disease  
Due to Pneumonia

Other conditions 191 B  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_  
Of autopsy Yes  
God above

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? \_\_\_\_\_

(e) Means of injury \_\_\_\_\_  
(Specify type of place)

23. Signature (Signature) (M. D. or other) MD  
Address (Address) Date signed 1-20-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

11  
1  
7

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**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.

*Nat Embalmer*

Signed.....

Licensed Embalmer No.....

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, fact should be so stated above.**