

No. 2
11-10-39
5-17-39
K X21492

FILED JUL 10 1949

Vanburen Sup. 23053

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 906

Primary Registration District No. 6219

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Rural
(c) Name of hospital or institution:
(d) Length of stay: In hospital or institution

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright
(c) City or town Rural
(d) Street No.
(e) If foreign born, how long in U. S. A.?

In this community _____ years, months or days

8. (a) PRINT FULL NAME Lydia E. Clark

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single widowed married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 20 - 1884

8. AGE: Years 56 Months 11 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Mo.

10. Usual occupation Housewife

11. Industry or business _____

12. Name Cyrus Parker

13. Birthplace Tenn

14. Maiden name Annie Andrews

15. Birthplace Ark

16. (a) Informant Ruby Henry

(b) Address Committee

17. (a) Rural (b) Date thereof 6/4-49

(c) Place: burial or cremation Friendship

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

19. (a) 6-4 49 (b) W. W. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2 year 1949 hour 12:00 minute _____ a. m.

21. I hereby certify that I attended the deceased from May 31 1949 to June 1 1949 that I last saw her alive on June 1 1949 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure Duration _____

Due to Congestion of throat & left lung

Due to paralysis of throat

Other conditions Feeble mind

Major findings: _____

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature W. B. Anderson (M. D. or other) _____

Address Vanburen, Mo. Date signed 6-2-49

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 741-1053

Date Filed JUL 9 1941

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

Russell Barber

Licensed Embalmer No. 3848

P. O. Address 17th Street

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. 23053

Registration District No. 906

Primary Registration District No. 6219

Registrar's No. 13

1. PLACE OF DEATH:
(a) County Wright
(b) City or town _____
(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

8. (a) PRINT FULL NAME Lydia E. Clark
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced _____
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 _____ 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 _____
18. 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's own signature _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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 June day 2
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 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 Heart failure
Chronic Myocarditis due to high blood pressure ← Chronic
Due to Congestion of throat & left lung
Due to Pharyngitis of throat & Cerebral hemorrhage
Other conditions Feeble mind
(Include pregnancy within 8 months of death)
Major findings: Paralysis & feeble mind caused by Cerebral hemorrhage
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 W. B. Anderson (M. D. or other) DC
Address Mountain Grove Mo Date signed _____

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

SPECIAL INVESTIGATION

5-23053

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 comply with the above constitutes grounds for revocation of license.)

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