

FILED OCT 23 1942

Registration District No. 150

Primary Registration District No. H 2 29

Registrar's No. 110

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Leis Summit  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: South Johnson St 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 32 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Leis Summit  
(If outside city or town limits, write "RURAL")

(d) Street No. So Johnson St  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Reed Clark

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8  
year 1942 hour 9:30 minute \_\_\_\_\_ a. M.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Sarah Ann Clark

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: Jan 17 - 1864  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 21, 1942 to Oct. 8, 1942  
that I last saw him alive on Oct. 8, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage

8. AGE: Years 78 Months 8 Days 21  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) § 30

9. Birthplace New York ny  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business General Labor

12. Name Joseph Clark

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

14. Maiden name Mary

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant Sarah Ann Clark

(b) Address Leis Summit Mo

17. (a) Burial (b) Date thereof 10-10-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leis Summit Mo

18. (a) Signature of funeral director H. B. Langeford

(b) Address Leis Summit Mo

19. (a) Oct 10, 1942 (b) F. N. Schick  
(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? \_\_\_\_\_

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

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

23. Signature Clint Miller (M. D.)  
Leis Summit MO Date signed 10-9-42

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

48  
0

48  
0

MOTHER FATHER

**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.....

*W.B. Langford*

Licensed Embalmer No..... *3838*

P. O. Address..... *Leis Summit, Mo*

**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.