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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 18 1942

Registration District No. 315

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41763

Primary Registration District No. 6066

Registrar's No.

1. PLACE OF DEATH:

(a) County: St. Clair

(b) City or town: Roscoe (Rural) (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: / Wash Temp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community: All of Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St. Clair

(c) City or town: Roscoe (Rural) (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

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

If yes, name country: 0

3. (a) PRINT FULL NAME: Francis Clark

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: M

5. Color or race: W

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

6. (b) Name of husband or wife:

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

7. Birth date of deceased: April (Month) 2 (Day) 1857 (Year)

8. AGE: Years: 85 Months: 7 Days: 7 If less than one day: hr. min.

9. Birthplace: Indiana (City, town, or county) / (State or foreign country)

10. Usual occupation: Farming

11. Industry or business: Retired

FATHER

12. Name: Owen Clark

13. Birthplace: Ireland (City, town, or county) 4 (State or foreign country)

MOTHER

14. Maiden name: Unknown Whaley

15. Birthplace: Ireland (City, town, or county) 4 (State or foreign country)

16. (a) Informant: J. A. Smith

(b) Address: Roscoe Missouri

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 11-10-42 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~: Roscoe Cemetery

18. (a) Signature of funeral director: Osceola Funeral Home

(b) Address: Osceola Missouri

19. (a) 11-9-42 (Date received local registrar) (b) F. B. Goodrich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov; day: 9th; year: 1942 hour: 4:30 minute: p 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.

	Duration
Immediate cause of death: Heart trouble and infirmities of old age.	
Due to: From family history he had previously suffered attacks.	
Due to: Found dead in bed, no evidence of violence.	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

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: 0

23. Signature: Farrell B. Goodrich Coroner (M. D. or other)

Address: Osceola Mo. Date signed: 11-9-42

11 0 4

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number 12-42-1366
Date Filed 12-11-42

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 Chas Gilbert Hathaway

Licensed Embalmer No. 4267

P. O. Address Decoda, 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.

. S. No. 2B
OM—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41763

Registration District No. 315 Primary Registration District No. 6066 Registrar's No.

1. PLACE OF DEATH:

(a) County St Clair

(b) City or town Rural
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Francis Clark

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April 2 1857
(Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days If less than one day hr. min.

9. Birthplace Indiana
(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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1942 hour minute M.

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

Immediate cause of death myocarditis chronic acute

Due to

Due to

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (c) Means of injury

23. Signature Jerred A Hundred (M. D. or other)
Address Coroner St Clair Co Mo Date signed 2 of 42

SUPPLEMENTARY