

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

proville

State File No. **11630**

FILED MAR 17 1943
Registration District No. **333**

Primary Registration District No. **3074**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(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
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
(c) City or town Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. 822 Mathews St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3
year 1943 hour 8 minute 00 P. M.
21. I hereby certify that I attended the deceased from Jan 30-43
1943 to Feb 3 1943
that I last saw him alive on Feb 2 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory pneumonia
Duration _____

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

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced, Infant
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if _____ years
7. Birth date of deceased Nov 23 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 10
If less than one day _____ hr. _____ min.

9. Birthplace Scott Co. County
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____
12. Name Ben J. Clark
13. Birthplace Unknown part
(City, town, or county) (State or foreign country)
14. Maiden name Grace J. Jettrell
15. Birthplace Pike Co. 1. Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Ben J. Clark
(b) Address Panton mo

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Willet Funeral Home
(b) Address Sikeston mo

19. (a) 3/7/43 (b) Louis Legend
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
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)
(a) Means of injury _____
23. Signature W. H. Proville (M. D. or other) _____
Address Sikeston mo Date signed 2-22-43

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

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

RECEIVED

District Health Office No. 2,

District File Number 343-374

Date Filed 3-16-43

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

Jack Kelley

Licensed Embalmer No. 3788

P. O. Address Sikeston 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11630
Registrar's No. 2

Registration District No. 333 Primary Registration District No. 3074

1. PLACE OF DEATH:
(a) County 5 cett
(b) City or town Likerton
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Wayne Allen 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 5
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 23 1914
(Month) (Day) (Year)

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

9. Birthplace _____ (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) _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb 1943 year, 11 hour 05 minute 00 M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____, that I last saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia Duration _____
Due to No complications listed
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: 107
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 Wm P. Peadar (M. D. or other) _____
Address Likerton Mo Date signed 2-22-43

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

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

SUPPLEMENTARY

S-11630