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No. 2
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5-17-35
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. 1838

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week. (Specify whether)

In this community 1 week. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 610 Miller St. (If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME Charles Wayne Clark

3. (b) If veteran, name war no

3. (c) Social Security No. none

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 alive..... years

7. Birth date of deceased Aug 6 - 1941
(Month) (Day) (Year)

8. AGE: Years 1 Months 8 Days 11 If less than one day hr. min.

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

10. Usual occupation infant

11. Industry or business.....

12. Name Chas E. Clark

13. Birthplace Table Rock Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mattie Ruth Falloway

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

16. (a) Informant Chas E. Clark

(b) Address Leis Summit Mo.

17. (a) Burial (b) Date thereof 4-19-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leis Summit Mo.

18. (a) Signature of funeral director M. Schick

(b) Address Leis Summit Mo.

19. (a) 4-18-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 17
year 1943 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from 4/10/43 19... to 4/17/43 19...
that I last saw him alive on 4/17/43 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic glomerular nephritis

Due to 121 B

Due to.....

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy see of me

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?.....

While at work (Specify type of place) (e) Means of injury 4/17/43

23. Signature M. Schick (M. D. or other) 3
Address Leis Summit Mo. Date signed 4/17/43

JUN 29 1943

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.....
.....
working under my personal supervision.

Registered Apprentice No.
Signed *F. M. Schick*
Licensed Embalmer No. *1856*
P. O. Address *Leis Summit*

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.