S. No. 2
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FILED APR 26 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13698

Registration District No. 42 Primary Registration District No. 1060 Registrar's No. 425

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Joseph, Hosp 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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 1114 Lincoln St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Clyde W. Dart
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lois Dart
6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased Oct (Month) 21 (Day) 1894 (Year)

8. AGE: Years 48 Months 5 Days 18 If less than one day hr. min.
9. Birthplace Pickwell (City, town, or county) Nebr (State or foreign country)
10. Usual occupation Fruit Salesman
11. Industry or business
FATHER 12. Name Frank Dart
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant Lois Dart
(b) Address St Joseph Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-43 (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cemetery
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address 1946 Calhoun St.
19. (a) 4-12-43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10 year 1943 hour 1 minute 30 a.m.
21. I hereby certify that I attended the deceased from March 18, 1943, to April 10, 1943; that I last saw him alive on April 9, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bacterial Endocarditis	2 wks
Meningitis, pneumoccus	
Due to: Heart disease, endocarditis	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 9/a	
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 [signature] (M.D. or other) M.D.
Address Social Welfare Board Date signed 4-14-43

1233

(Licensed Embalmer's Statement on Reverse Side)

APR 26 1949
JAN 12 1949
FEB 13 1951

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 Robert R. Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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.