

27819

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registered District No. 1024

Primary Registration District No. 4048 4062

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Cowgill Mo.  
(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 Mo (b) County Caldwell

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

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

(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Fred S. Clark

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. 496-59-4269

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15 year 1943 hour 10 minute 30 P.

4. Sex Male 5. Color or race White

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

(b) Name of husband or wife Fred S. Clark (c) Age of husband or wife if alive 62 years (Day) (Year)

7. Birth date of deceased Oct 27 1981  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 5, 1943 to Aug. 15, 1943 that I last saw him alive on Aug. 15, 1943 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>9</u>	<u>23</u>	hr. _____ min. _____

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

Immediate cause of death Bronchial Pneumonia Duration 10 days

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name David Clark

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

14. Maiden name Eddie Griffin

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

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

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

Other conditions (Include pregnancy within 3 months of death) O. C. Kilbourn MD

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

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

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

16. (a) Informant's own signature Mrs. Bertie Clark

(b) Address Cowgill Mo.

17. (a) Burial (b) Date thereof Aug 17 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cowgill Mo.

18. (a) Signature of funeral director Clayton A. Keen

(b) Address Cowgill Mo.

19. (a) Aug 18 1943 (b) B. E. Thompson  
(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 \_\_\_\_\_

28. Signature O. C. Kilbourn (M. D. or other) M.D.

Address Cowgill, Mo. Date signed 8/16/43

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FORM 1 1938

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**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. Reed*

Licensed Embalmer No. 2194E

P. O. Address Council No

**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, above space should be left blank.**