

S. No. 2
M-5-43
7-5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **120520**
Registrar's No. **2591**

FILED JUN 29 1944
Registration District No. **1002**

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 Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6-13-44 6-19-44
(Specify whether
 In this community 10 58 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**
 (c) City or town Kansas City **38**
(If outside city or town limits, write "RURAL")
 (d) Street No. Phillips Hotel **8**
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 10

3. (a) PRINT FULL NAME (Judge) Charles H. CLARK
 (b) If veteran, name war no
 (c) Social Security No. none
 4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced single
 (c) Age of husband or wife if alive 0 years
 7. Birth date of deceased January 27 1870
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19
 year 1944 hour 3:20 minute P M.
 21. I hereby certify that I attended the deceased from 6-13-44
 _____, 19____, to 6-19-44, 19____;
 that I last saw him alive on 6-19-44, 19____;
 and that death occurred on the date and hour stated above.

8. AGE: Years 74 Months 4 Days 22
 If less than one day _____ hr. _____ min.
 9. Birthplace _____
(City, town, or county) (State or foreign country)
 10. Usual occupation Justice of the Peace
 11. Industry or business Judge

Immediate cause of death Pneumonia
 Due to Uremia **2 days**
 Due to Possible Ca. of Prostate **year**
 Other conditions 51 lb
(Include pregnancy within 3 months of death)

MOTHER FATHER {
 12. Name _____
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace _____
(City, town, or county) (State or foreign country)
 16. (a) Informant St. Joseph Hospital
 (b) Address Kansas City, Missouri
 17. (a) Burial (b) Date thereof June 21 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary
 18. (a) Signature of funeral director Melody McElley
 (b) Address Linwood at Euclid
 19. (a) 6-20-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

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)
 (e) Means of injury _____
 23. Signature J. Albert Higgins (M. D. or other)
 Address 625 Argyle St. Date signed 6/20/44

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

Dr. D. M. High
Regyle Red.

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.....

J. H. Payne
2999

.....
Licensed Embalmer No.....

P. O. Address.....
KC

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.