

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

X32873

FILED JUN 20 1944  
Registration District No. 4238

Primary Registration District No. 4238

1. PLACE OF DEATH:

(a) County Knox

(b) City or town Edina  
(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) 1

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community all life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin 52

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") 0

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

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jane Clark

3. (b) If veteran, name was \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27 year 1944 hour 1 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from April 1st 1940 to April 27 1944 that I last saw her alive on April 3 1944 and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Thos 6. (c) Age of husband or wife 81 yrs alive \_\_\_\_\_ years

7. Birth date of deceased Apr 29 1963 (Month) (Day) (Year)

Immediate cause of death Acute Dilatation of Heart

Duration short

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

80 11 29 hr. \_\_\_\_\_ min.

Due to Hypertension

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

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Retired

May findings: Of operations \_\_\_\_\_

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

11. Industry or business none

PHYSICIAN 9504

Underline the cause to which death should be charged statistically.

12. Name James P. P.

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

14. Maiden name Mary Halman

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

16. (a) Informant W. T. Delaney

(b) Address Edina Mo

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 4-29-44 (Month) (Day) (Year)

(c) Place: burial or cremation New St. Joseph's Cemetery

18. (a) Signature of funeral director L. B. Kelly & Co

(b) Address Edina Mo

19. (a) 4-28-44 (Date received local registrar) (b) Nelle Northcutt (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 \_\_\_\_\_

Signature M. G. Linnain (M. D. or other) \_\_\_\_\_

Address Edina Mo Date signed April 27 1944

RECEIVED

District Health Officer No. 10

District File Number 6-44-1192

Date Filed JUN 15 1944

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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.....

Licensed Embalmer No. 2755

P. O. Address..... London 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.

5-43  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July 20  
Registrar's No. \_\_\_\_\_

Registration District No. 169

Primary Registration District No. 4258

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

1. PLACE OF DEATH:

(a) County Knox

(b) City or town Edina  
(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 Jane Clark

3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 29 1886  
(Month) (Day) (Year)

8. AGE: Years 80 Months 11 Days 29 If less than one day \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

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) Nelle Northcutt  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Knox

(c) City or town Edina  
(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 April Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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

Duration \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

21857