

FILED AUG 14 1944

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

24392

State File No. _____

Registration District No. 6

Primary Registration District No. 5242

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Chariton
 (b) City or town Rural "Bee Branch"
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Home 10 miles south of New Cambria
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 1
(Specify whether)
 In this community 74 years
years, months or days

3. (a) PRINT FULL NAME EMSLEY CYRUS CLARK

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 Widowed
 6. (b) Name of husband or wife Hattie Edna Clark 6. (c) Age of husband or wife if alive — years
 7. Birth date of deceased July 14 1870
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 29 If less than one day — hr. — min.

9. Birthplace Chariton Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business "

MOTHER FATHER { 12. Name Samuel Clark
 13. Birthplace Illinois
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah Jane Christman
 15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Cloner Clark

(b) Address New Cambria Mo.

17. (a) Burial (b) Date thereof July 16 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Johnson Cemetery

18. (a) Signature of funeral director H. P. Silliland

(b) Address New Cambria Mo.

19. (a) H. J. Jones (b) R. H. Hebrug
(Data received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton 21
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 10 miles south of New Cambria
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13
 year 1944 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 5th 1944 to July 13th 1944
 that I last saw him alive on July 13th 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Poison Duration 2 mo
—
 Due to Postatic Thrombosis 1 yr
—
 Due to —

Other conditions —
(Include pregnancy within 5 months of death)

Major findings: 137a
 Of operations —
 Of autopsy no

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 —

23. Signature Q. West (M. D. or other) 0
 Address New Cambria Mo. Date signed July 14 1944

1024

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 8-11-59

MAR

4 1959

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 H. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria, 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.