No. 2
8-43
7-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27250

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. ~~799~~ 881

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: 2620 Folsom St /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 4 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrew 2
(c) City or town Whitesville 2
(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 .....

3. (a) PRINT FULL NAME Benjiman Franklin Clark

3. (b) If veteran, name war — 3. (c) Social Security No. —

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

6. (b) Name of husband or wife Zilpha Clark — 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased May (Month) 31 (Day) 1865 (Year)

8. AGE: Years 79 — Months 3 — Days 1 — If less than one day ..... hr. ..... min.

9. Birthplace Unknown (City, town, or county) Ill (State or foreign country) /

10. Usual occupation Farmer

11. Industry or business .....

FATHER
12. Name Simeon Clark /
13. Birthplace Unknown (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Marian Porter /
15. Birthplace Unknown (City, town, or county) Ind (State or foreign country) /

16. (a) Informant Zelpha Clark
(b) Address 2620 Folsom St St Joseph

17. (a) B. (Burial, cremation, or removal) (b) Date thereof 9 (Month) 4 (Day) 1944 (Year)
(c) Place: burial or cremation Flagspring Mo

18. (a) Signature of funeral director E. C. Brett
(b) Address Savannah Mo

19. (a) 9/7/44 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 2 year 1944 hour 8 p.m. minute ..... M.

21. I hereby certify that I attended the deceased from Sep 1, 1944 to Sep 2, 1944 that I last saw him alive on Sep 2, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Shock from Comp Fract left Knee	24 hrs
Due to Concussion of Praslate & Vertebra	1 yr
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 131
(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 J. M. Alexander (M. D. or other)
Address Cofran Bldg — Date signed 9/6/44

1377 (Licensed Embalmer's Statement on Reverse Side)

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 E. C. Brat

Licensed Embalmer No. 2650

P. O. Address Savannah Me

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

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:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 4 da
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(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 .....

3. (a) PRINT FULL NAME Benjamin F. Clark

3. (b) If veteran, name war .....

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

4. Sex M

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 65 years

7. Birth date of deceased May (Month) 31 (Day) 1865 (Year)

8. AGE: Years 79 | Months 3 | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day ..... year 1944 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...; that I last saw h..... alive on ..... 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Shock from Compound fracture left knee

Due to Carcinoma of prostate & vertebrae

Due to .....

Other conditions 186a
(Include pregnancy within 3 months of death)

Major findings:
Of operations ..... ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy .....

Duration: 24 hrs.

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 Sep 1-44

(c) Where did injury occur? His Home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
St Joseph MO
(Specify type of place)

While at work? no (e) Means of injury fall

23. Signature J M Alleman (M. D. or other)

Address Cynthia Bldg St Joseph MO Date signed 9/11/44

SUPPLEMENTARY

27249