

2
-5-43
-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1945
337

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3742
Registrar's No. 2

Registration District No. 337 Primary Registration District No. 4497

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

1. PLACE OF DEATH:

(a) County SHELBY

(b) City or town CLARENCE MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(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 3.5 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County SHELBY MO

(c) City or town CLARENCE MO
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 11

3. (a) PRINT FULL NAME WILBERT H STARK

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 MARRIED

6. (b) Name of husband or wife CORA 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased MAY 8 - 1867
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4
year 1945 hour 10 minute 45 a.m.

21. I hereby certify that I attended the deceased from Jan 2 1945 to Jan 4 1945
that I last saw him alive on Jan 3 1945
and that death occurred on the date and hour stated above.

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

77 7 27 hr. _____ min.

Immediate cause of death: Cerebral apoplexy
C R hemiplegia

Due to _____

Due to _____

Other conditions: g/20
(Include pregnancy within 3 months of death)

Duration
3 days

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

10. Usual occupation FARMER

11. Industry or business MR STARK

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

12. Name Not known

13. Birthplace Not known
(City, town, or county) (State or foreign country)

14. Maiden name MARtha WILSON

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs CORA STARK
(b) Address CLARENCE MO

17. (a) BURIAL (b) Date thereof 1/6-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MAPLEWOOD

18. (a) Signature of funeral director William A Barklow
(b) Address CLARENCE MO

19. (a) Jan 4-40 (b) Madge Good
(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 _____

23. Signature D. L. Hulon MO
Clarence MO (M. D. or other)
Address _____ Date signed 4/6/45

1095 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 2-45-231

Date Filed FEB 11 1945

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 Clifford H. Hawkes

Licensed Embalmer No. 2495

P. O. Address Shelburne, Vt

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.