S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1945

Registration District No. 387

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 45-15

Felder.

State File No. 7357

Registrar's No.

1. PLACE OF DEATH:
(a) County: Sullivan
(b) City or town: Milan (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 years, months or days) In this community: 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Sullivan
(c) City or town: Milan (If outside city or town limits, write "RURAL") 1
(d) Street No. ____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country ____

3. (a) PRINT FULL NAME: Mary Alzada Clark
3. (b) If veteran, name war: no
3. (c) Social Security No.: —
4. Sex: F M 1
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or ~~wife~~: Chas Clark
6. (c) Age of husband or wife if alive: 68 years
7. Birth date of deceased: 4 (Month) 10 (Day) 1883 (Year)
8. AGE: Years 61 Months 8 Days 29 If less than one day ____ hr. ____ min.
9. Birthplace: Pollock (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation: House wife
11. Industry or business ____
12. FATHER Name: Ananias Campbell
13. FATHER Birthplace: Pollock (City, town, or county) Mo (State or foreign country) 0
14. MOTHER Maiden name: Josephine Willis
15. MOTHER Birthplace: Pollock (City, town, or county) Mo (State or foreign country) 0
16. (a) Informant: Cell Creason
(b) Address: Pollock Mo
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof: 1-5-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Campbell Cem
18. (a) Signature of funeral director: Adams Funeral Dir.
(b) Address: Milan Mo
19. (a) Feb. 5-45 (Date received local registrar) (b) Mrs. L. D. Green (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 3 year 1945 hour 10 minute 10 a M.
21. I hereby certify that I attended the deceased from December 24, 1944 to January 3, 1945 that I last saw her alive on January 3, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma of the breast	2 years
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy —	

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: Dr. Frank Felder (M. D. or other) D.O.
Address: Milan, Mo. Date signed: 1/3/45

1190

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-45-381
Date Filed FEB 28 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.....

Licensed Embalmer No.....

P. O. Address.....

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.