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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12618

FILED MAY 28 1945  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3000

Registrar's No. 111

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution Smith Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 hour  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Gulliver

(c) City or town Pewville 10.5  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_  
(If rural, give location) 0

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

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

3. (a) PRINT FULL NAME CARROLL ANN CLARK

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 28th day April  
year 1945 hour 9 minute 35 M.

21. I hereby certify that I attended the deceased from April 28 1945 to April 28 1945  
that I last saw her alive on April 28 1945  
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 S

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

7. Birth date of deceased Aug 7 1943  
(Month) (Day) (Year)

Immediate cause of death Pneumonia

Due to Water green pneumonia

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

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

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

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

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

1 8 21 hr. min.

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

10. Usual occupation \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

ATTEST  
SUPPLEMENTARY INFORMATION REQUESTED

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Harold Clark

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

14. Maiden name Genevieve Bhauser

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

16. (a) Informant Harold Clark

(b) Address Green City Mo

17. (a) Burial (b) Date thereof 4 30 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burnett

18. (a) Signature of general director Glen E. Hartson

(b) Address Green City Mo

19. (a) 5-1-45 (b) Wm. J. Wayman  
(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 4-27-45

(c) Where did injury occur? Pittsburg Mo  
(City or town) (County) (State)

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

(e) Means of injury \_\_\_\_\_

23. Signature Arles Caldwell (M. D. or other) \_\_\_\_\_  
Address Pittsburg Mo Date signed 4-28-45

1649 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 10

District File Number 5-45-846

Date Filed MAY 10 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 *Archie W. Wade*

Licensed Embalmer No. 3037

P. O. Address *Green City, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. main  
Registrar's No. 111

Registration District No. 1 Primary Registration District No. 3000

1. PLACE OF DEATH:  
(a) County Adair  
(b) City or town Kirkville  
(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)

3. (a) PRINT FULL NAME Carroll A 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. 5

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

7. Birth date of deceased Aug 7  
(Month) (Day) (Year)

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

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

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) (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)

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.

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month Aug Day 13 Year 1945 hour 11 minute 15 M.  
21. I hereby certify that I attended the deceased from 11:15 to 11:30 AM that I last saw him alive on Aug 13 and that death occurred on the date and hour stated above. Immediate cause of death Heart

Due to  
Due to

Other conditions. (Include pregnancy within 3 months of death)  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations. Of autopsy. 179  
113

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence 4-13-45  
(c) Where did injury occur? between (City or town) (County) (State) mo  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home of neighbor  
While at work? (Specify type of place) (e) Means of injury falling  
23. Signature Alfred (M. D. or other) Pharmacist  
Address Pharmacist Date signed 4-16-45

SUPPLEMENTARY

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

12618