No. 2
8-43
5-17-39
I X37023

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28685

Registration District No. 338 Primary Registration District No. 6148 Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard Co.

(b) City or town Rural - Castor Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: County Home 5
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard 103

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

(d) Street No. County Home 0
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME Ida Clark

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced 7

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 19 (Month) (Day) 1890 (Year)

8. AGE: Years 55 years | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Don't Know
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Don't Know
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Jess Aslin
(b) Address Bloomfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation County Farm

18. (a) Signature of funeral director Jess Aslin
(b) Address Bloomfield Mo

19. (a) 8-23-1945 (Date received local registrar) (b) Pearl Elmore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19
year 1945 hour 9 minute 45 a. M.

21. I hereby certify that I attended the deceased from Aug. 15, 1945 to Aug. 19, 1945
that I last saw her alive on Aug. 18, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
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 John Wilson (M.D. or other)
Address Bloomfield, Mo. Date signed 8/22/45

1130

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File Number 945-2
Date Filed 9-6-4

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.

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Rural Castor Twp
(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

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 Ida 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 Widow

6. (b) Name of husband or wife (Dont Known)

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

7. Birth date of deceased Aug 19 (Month) (Day) (Year)

8. AGE: Years 55 Months Days If less than one day hr. min.

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

10. Usual occupation Inmate of C. House

11. Industry or business House work

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 Aug Day 19 year 1942 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 — Duration

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-28685