V. S. No. 2
OM—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

33147

State File No.

FILED OCT 24 1945

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1077

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No 22
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Mo 11 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Jackson 11

(c) City or town: Kansas City 1
(If outside city or town limits, write "RURAL")

(d) Street No.: 412 7 11 St 7
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 9

If yes, name country

3. (a) PRINT FULL NAME: Harry E Clarke

3. (b) If veteran, name war: No

3. (c) Social Security No.: 40

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: not stated

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

7. Birth date of deceased: 2 (Month) 22 (Day) 1877 (Year)

8. AGE: Years 68 Months 7 Days 13 If less than one day hr. min.

9. Birthplace: Ind. 1 (City, town, or county) (State or foreign country)

10. Usual occupation: actor + teacher

11. Industry or business

FATHER
12. Name: Not given
13. Birthplace: not given 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: not given
15. Birthplace: Not Given 1 (City, town, or county) (State or foreign country)

16. (a) Informant: Record Hospital 1
(b) Address: St Joseph Mo

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof: 10/8/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Elmwood Cem

18. (a) Signature of funeral director: Stine-McClure
(b) Address: Kansas City Mo.

19. (a) 10-6-1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5 year 1945 hour 3-15 minute a M.

21. I hereby certify that I attended the deceased from 7-24, 1945 to 10-5, 1945 that I last saw h— alive on 10-4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis — Duration

Due to: arteriosclerosis

Due to:

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

Major findings:
Of operations: 0/No

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: E E Salyer (M. D. ~~or other~~)

Address: St Joseph Mo, Date signed 10/5/45

142 V (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.....

Licensed Embalmer No. 1415

P. O. Address K. C. 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.