

No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

38028

FILED DEC 7 1945

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 237

Primary Registration District No. 58204353

Registrar's No. 208

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

1. PLACE OF DEATH:

(a) County new madrid

(b) City or town Gideon

(c) Name of hospital or institution: Hopkins clinic
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

3. (a) PRINT FULL NAME CAROLYN SUE 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 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 11 (Month) 17 (Day) 45 (Year)

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

2 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Walter C Clark

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

14. Maiden name Mary E. Newton

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

16. (a) Informant Walter C. Clark

(b) Address Gideon, mo.

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

(c) Place: burial or cremation Stanfield Cemetery

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Nov. 18, 1945 (b) Mrs. Byron Sharp
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo. (b) County new madrid

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

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17
year 45 hour 11 P.M. minute 20 P.M.

21. I hereby certify that I attended the deceased from 11/17/45, 19____, to 11/17/45, 19____;
that I last saw her alive on 11/17/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth

Due to _____

Due to _____

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

Major findings: _____
Of operations 159

Of autopsy _____

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 0

23. Signature F. S. Hopkins (M. D. _____)
Address Gideon mo Date signed 11/18/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1548

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,
District File Number 1245-3342
Date Filed 12-5-45

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.

Registration District No.

237

Primary Registration District No.

4353

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid
 (b) City or town St. Louis
 (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 _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME

Carolyn S. Clark3. (b) If veteran,
name war _____3. (c) Social Security
No. _____

4. Sex

F5. Color or
race W6. (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

Nov. 17
(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

(Unless than one day)

9. Birthplace

(City, town, or county)

(State or foreign country) Mo.

10. Usual occupation

11. Industry or business

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
(Burial, cremation, or removal)(b) Date thereof Nov. 18, 1946
(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

Family

(b) Address

Gideon, Mo.

19. (a) _____

(b) _____

(Date received local registrar)

(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 Nov
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ 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 sta-
tistically.

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 _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

38028