

FILED AUG 12 1946

Primary Registration District No. 3041

Registrar's No. 81

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Francis S. Clark
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Dec 1 - 1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Richard Pearson
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name no record

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

16. (a) Informant Helen Kelly
(b) Address Macon

17. (a) burial (b) Date thereat June 17-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director Robert Skinner

(b) Address Macon Mo

19. July 23 1946 (Date received local registrar) Irish McNeely (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
(c) City or town Macon
(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 June day 15
year 1946 hour 1 minute 2 M.

21. I hereby certify that I attended the deceased from 6-4-46 to 6-15-46
that I last saw her alive on 6-15-46 and that death occurred on the date and hour stated above

Immediate cause of death _____

Cerebral Hemorrhage Duration 15-20 min

Due to Hypertension 5 yrs

Due to arteriosclerosis 5 yrs

Other conditions arteriosclerosis

Major findings: Of operations none

Of autopsy none

Duration

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) no

(b) Date of occurrence no

(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? no

While at work? no (Specify type of place) (e) Means of injury no

23. Signature M.D. Address _____ Date signed 6-17-46

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

COPIES

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OCT 14 1948

RECEIVED
District Health Officer No. 10
District File Number 2-46-1464
Date Filed AUG 10 1948

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 Albert S. Keener

Licensed Embalmer No. 75-1

P. O. Address Macon 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.