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FILED SEP 10 1946

Registration District No. **294**

Primary Registration District No. **3056**

1. PLACE OF DEATH:

(a) County **Randolph**
(b) City or town **Moberly Missouri**
(c) Name of hospital or institution: **Wabash Employees Hosp 915 Woodland Moberly Mo**
(d) Length of stay: In hospital or institution **3 days**
In this community **3 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **Randolph 88**
(c) City or town **MOBERLY 6**
(d) Street No. **404 E. Logan 3**
(e) Citizen of foreign country? **0**

3. (a) PRINT FULL NAME

John W. Clark

3. (b) If veteran, name war

3. (c) Social Security No. **702-05-6902**

4. Sex **MALE C**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **23** years (Day) (Year)

7. Birth date of deceased **Aug 23rd 1885**

8. AGE:

Years **62** Months **11** Days **25** hr. min.

9. Birthplace:

Illinois

10. Usual occupation

RETIRED Road Supt.

11. Industry or business

WABASH RAILROAD

MOTHER FATHER

12. Name **Hoyace Clark**

13. Birthplace **N.J.**

14. Maiden name **Clara Stevens**

15. Birthplace **U.K. 9**

16. (a) Informant

Mrs Robt Mc Atee

(b) Address

Moberly

17. (a)

Burial

(b) Date thereof **Aug 20 1946**

(c) Place: burial or cremation

Moberly Mo

18. (a) Signature of funeral director

Mathew Law

(b) Address

Moberly Mo

19. (a)

Aug 20 46

(b) Registrar's signature **Leah Sullivan**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **18** year **1946** hour **5** minute **35 AM**

21. I hereby certify that I attended the deceased from **Aug 18 1946** to **Aug 18 1946** that I last saw him alive on **Aug 18 1946** and that death occurred on the date and hour stated above.

Immediate cause of death

Broncho pneumonia 24 hrs

Due to

cerebral hemorrhage 3 days
generalized arteriosclerosis years

Due to

Chronic myocarditis years
hypertension years

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **not done**

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)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

23. Signature **Leah Sullivan** (M. D. or other)

Address **Wabash Hosp Moberly Mo** Date signed **9-18-46**

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

JAN 29 1948
NOV 19 1947

OCT 3 1946

RECEIVED
District Health Officer No. 10
District File Number 9-46-1665
Date Filed SEP-7-1946

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 *Frank W. DeWitt*

Licensed Embalmer No. *3021*

P. O. Address *Moberly 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.

Registration District No. 294 Primary Registration District No. 3056

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(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 John W. Clark
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug (Month) 19 (Day) 18 (Year)

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

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

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Aug 20 - 46 (b) Paul William Love
(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 _____ Year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

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

Major findings:
Of operations _____
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 _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

28067