

No. 2  
8-43  
17-39  
37823

**FILED DEC 19 1946**

Registration District No. **96**

Primary Registration District No. **415-8**

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

1. PLACE OF DEATH:

(a) County **Dallas**  
(b) City or town **Buffalo**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **home**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **K** County **30**  
(b) City or town **0**  
(If outside city or town limits, write "RURAL")  
(c) Street No. **0**  
(If rural, give location)  
(d) Citizen of foreign country? **0** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Mary Robinson 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 **Widow**

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

7. Birth date of deceased **Nov. 4<sup>th</sup> 1944**  
(Month) (Day) (Year)

8. AGE: Years **82** Months **1** Days **2** If less than one day hr. min.

9. Birthplace **Detroit Michigan**  
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business

12. Name **James Voakes**

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

14. Maiden name **Bridget Campbell**

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

16. (a) Informant **Richard J. Clark**  
(b) Address **Buffalo, Mo.**

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation **West Plains, Mo.**

3. (a) Signature of funeral director **W. B. Jones**  
(b) Address **Buffalo, Mo.**

3. (c) **Dec 11, 1946** (b) **W. B. Jones**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** Day **6**  
year **1946** hour minute M.

21. I hereby certify that I attended the deceased from **28 Nov 46** to **5 Dec 1946**  
that I last saw her alive on **5 Dec 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal obstruction** Duration **10 days**  
Due to **Carcinoma of Colon** **2 mos?**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: **46E**  
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?

While at work? (Specify type of place) (c) Means of injury **0**

23. Signature **W. B. Jones** (M. D. or other) **MD**  
Address **Buffalo, Mo** Date signed **7 Dec 46**

RECEIVED  
District Health Officer No. 7,  
District No. 6-3107  
Date Filed 12-13-76

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 Maria B Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.

State File No. Jan  
Registrar's No. 87

Registration District No. 96 Primary Registration District No. 4158

1. PLACE OF DEATH:  
(a) County Dallas  
(b) City or town Buffalo  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State mo (b) County Dallas  
(c) City or town Buffalo  
(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 Mary R. Clark  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M. 6

4. Sex F 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: no. (Month) 4 (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

8. AGE: Years 82 Months 1 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 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) 12-11-46 (b) Grace Peterson  
(Date received local registrar) (Registrar's signature)

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?  
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

SUPPLEMENTARY

40070