

UNITED STATES BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED FEB 11 1947
1/33
Registration District No.

Primary Registration District No. **3022**

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

1. PLACE OF DEATH:

(a) County **Harrison**

(b) City or town **Bethany**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **none**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **none** (Specify whether)

In this community **50 years.**
years, months or days

3. (a) PRINT FULL NAME **Minnie L. Clark**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

4. Sex **Female**

5. Color or race **White**

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

6. (b) Name of husband or wife **William M.**

6. (c) Age of husband or wife if alive **Dec.** years

7. Birth date of deceased **10 - 13 - 1865**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	81	3	8	hr. min.

9. Birthplace **Hilliard Ohio.**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife.**

11. Industry or business **none**

MOTHER FATHER

12. Name **David Scofield**

13. Birthplace **do not know**
(City, town, or county) (State or foreign country)

14. Maiden name **Cornelia Thacker**

15. Birthplace **do not know**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Raymond Selby**

(b) Address **Bethany, Mo.**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **1-23-47**
(Month) (Day) (Year)

(c) Place: burial or cremation **Burris, Bethany, Mo.**

18. (a) Signature of funeral director **[Signature]**

(b) Address **Bethany, Mo.**

19. (a) **Jan 25 47** (Date received local registrar)

(b) **[Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Harrison**

(c) City or town **Bethany Twp. (Rural)**
(If outside city or town limits, write "RURAL")

(d) Street No. **4 miles South of Bethany.**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **21**
year **1947** hour **8** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **1 - 20**, 19**46** to **19**;
that I last saw her alive on **11 - 26**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma - of face -**

Duration **1 1/2 yrs.**

Due to **^ ^**

Due to **^ ^**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **53**

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 **^**

23. Signature **W.A. Brainer** (M. D. or other)

Address **Bethany Mo** Date signed **1-24-46**

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DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *W B Haas*

Licensed Embalmer No. *3899*

P. O. Address *Bithany, 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.