

No. 2
-12-45
5-17-39
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FILED MAY 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13241

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 33

1. PLACE OF DEATH:
(a) County HARRISON
(b) City or town BETHANY
(c) Name of hospital or institution: BETHANY HOSPITAL
(d) Length of stay: In hospital or institution 2 DAYS
In this community years, months or days

3. (a) PRINT FULL NAME VETA CLARK
3. (b) If veteran, name war
3. (c) Social Security No. 498-24-84-54

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 1 19 1927
(Month) (Day) (Year)

8. AGE: Years 20 Months 2 Days 20
If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business
12. Name ORA CLARK
13. Birthplace Mo. O
14. Maiden name OCTAVIA CLARK
15. Birthplace Mo. O

16. (a) Informant Ora Clark
(b) Address Bethany, Mo.
17. (a) Burial (b) Date thereof 4/12/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MARTINSVILLE, Mo.
18. (a) Signature of funeral director Thornton H. Haas
(b) Address Bethany, Mo.

19. (a) April 14-47 (b) Jolanda Burris
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County HARRISON
(c) City or town BETHANY
(d) Street No.
(e) Citizen of foreign country? No.
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day ninth year 1947 hour 3 minute 15 P.M.
21. I hereby certify that I attended the deceased from April 7 to April 9, 1947, that I last saw her alive on April 9, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia
Due to respiratory paralysis
Due to section of cervical cord from fracture & trauma
Other conditions Fracture body of cervical vertebrae 2
Duration -

PHYSICIAN
Major findings: Of operations none
Of autopsy none
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) incident car.
(b) Date of occurrence April 6, 1947
(c) Where did injury occur Exeter Springs, Mo.
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on highway

While at work? No
23. Signature Miriam Keasler (M. D. or other) MO
Address Bethany Date signed 12/26/47

Raw off Roadway

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

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..... *Thornton N. Haes*

Licensed Embalmer No. *2861*

P. O. Address..... *Bethany, 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.