

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED SEP 29 1947

Registration District No. 147 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Research Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 hours
 (Specify whether
 In this community 25 yrs.
 years, months or days)

3. (a) PRINT FULL NAME James Albert Clark
 3. (b) If veteran, name war XX 3. (c) Social Security No. none
 4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife Hattie M. 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased February 4 1869
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 7 12 _____ hr. _____ min.

9. Birthplace Keokuk Iowa
 (City, town, or county) (State or foreign country)

10. Usual occupation Interior Decorator

11. Industry or business Retired

12. Name not known 9

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

14. Maiden name not known 9

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

16. (a) Informant Mr. Ray R. Willard

(b) Address 423 West 66th Terrace

17. (a) burial (b) Date thereof 9-18-1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cmtry.

18. (a) Signature of funeral director Bentley Mortuary
 (b) Address 5811 Troost

19. (a) 9-18-47 (b) Geraldine Holmes
 (Date received local certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. 810 East 31st Terr. 8
 (If rural, give location) 0
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept. day 16
 year 1947 hour 9:15 minute P M.
 21. I hereby certify that I attended the deceased from Sept 13 1947 to Sept 16 1947
 that I last saw him alive on Sept 16 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
 Duration _____

Due to _____

Due to _____

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

Major findings: 9/10

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 Hemphill (M. D. or other) _____

Address 1014 W. 11th Date signed 9/17/47

Dr. H. C. Trippe
Argyle Bldg.
Ha. 3454

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.....

Guy Buffington

..... Licensed Embalmer No. *2756*

..... P. O. Address *K C 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.