DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1949

Registration District No. 36

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1057

Primary Registration District No. S499

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Harrison

(b) City or town Near Hatfield Mo. (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lincoln Twp. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community most of life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Harrison 41

(c) City or town Near Hatfield Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. Rural
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Fallie Hinkley 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 ✓ W

6. (b) Name of husband or wife Dan Clark

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

7. Birth date of deceased Aug. (Month) 4 (Day) 1861 (Year)

8. AGE: Years 87 Months 5 Days 16 If less than one day ..... hr. ..... min.

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

10. Usual occupation Home Keeper

11. Industry or business

MOTHER FATHER

12. Name William R Hinkley

13. Birthplace not known (City, town, or county) (State or foreign country)

14. Maiden name Laura Shook

15. Birthplace not known (City, town, or county) (State or foreign country)

16. (a) Informant Edgar L. Drake

(b) Address Mt. City Iowa

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22-49 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion (near Villisca Iowa)

18. (a) Signature of funeral director C. C. Rhooker

(b) Address Mt. City Iowa

19. (a) Jan 22 49 (Date received local registrar) (b) Chas. A. Dair Jr. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 20 year 1949 hour 3 minute A M.

21. I hereby certify that I attended the deceased from 1/6/49, 19..., to 1/20, 1949 that I last saw her alive on 1/19, 1949 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 wks
Due to Arteriosclerotic Cardio Vascular Disease	
Due to	
Other conditions (Includes pregnancy within 3 months of death) Congenital Blindness	Lifetime

Major findings:
Of operations None
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Frank B Mattson M.D. (Coroner or other)

Address Grant City, Mo. Date signed 1/21/49

(Licensed Embalmer's Statement on Reverse Side)

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 C. C. Rhoades

Licensed Embalmer No. 247-9

P. O. Address Mt Ayr Iowa

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

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