

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19232

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BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 498

1. PLACE OF DEATH
a. COUNTY Greene

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Greene

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, N. Campbell c. LENGTH OF STAY (in this place) 5 yrs

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, N. Campbell township

d. FULL NAME OF HOSPITAL OR INSTITUTION Greene Co. Hospital d. STREET ADDRESS (If rural, give location) Greene Co. Almshouse

3. NAME OF DECEASED (Type or Print)
a. (First) Wiley b. (Middle) Love c. (Last) Clark

4. DATE OF DEATH (Month) (Day) (Year)
June 4 1949

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH Nov. 7 - 1879 9. AGE (If years last birthday) 69 IF UNDER 1 YEAR Months 6 Days 27 IF UNDER 2 yrs. Hours 12 Min. 17

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Farming 11. BIRTHPLACE (State or foreign country) Illinois 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Robert Heywood Clark 13b. MOTHER'S MAIDEN NAME Polly Porter 14. NAME OF HUSBAND OR WIFE Edward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No (If yes, give war & dates of service) _____ 16. SOCIAL SECURITY NO. 944-18-3480 17. INFORMANT'S SIGNATURE OR NAME Mrs. Josephine Long ADDRESS 1215 West St

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from June 4, 1949, to June 4, 1949, that I last saw the deceased alive on June 4, 1949, and that death occurred at 6:30 p.m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James A. Brown M.D. 23b. ADDRESS 937 E. Lombard Springfield, Mo 23c. DATE SIGNED June 7, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE June 10, 49 24c. NAME OF CEMETERY OR CREMATORY Brookline Cem New Brookline Mo 24d. LOCATION (City, town or county) (STATE) _____

DATE REC'D BY LOCAL REG. 6/10/49 REGISTRAR'S SIGNATURE W.S. Handley 25. FUNERAL DIRECTOR'S SIGNATURE W.S. Handley ADDRESS 1111 Old Ocean Springfield Mo

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Ralph H. Thorne

Licensed Embalmer No. *3681*

P. O. Address *Springfield, 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.