

FILED JUL 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22962

BIRTH NO. _____		REG. DIST. NO. 100		PRIMARY REG. DIST. NO. 3018		Registrar's No. 53			
1. PLACE OF DEATH a. COUNTY Dent				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dent					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <del>Arax</del> Salem		c. LENGTH OF STAY (In this place) years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salem Mo		1			
d. FULL NAME OF HOSPITAL OR INSTITUTION X /				d. STREET ADDRESS (If rural, give location) XX					
3. NAME OF DECEASED (Type or Print) a. (First) William Henry			b. (Middle) Click		c. (Last) Click				
4. DATE OF DEATH (Month) (Day) (Year) 7 21 49		5. SEX male 0		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 1			
8. DATE OF BIRTH Jan 5 1882		9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Days 6		IF UNDER 24 HRS. Hours Min. 16			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) Missouri 0		12. CITIZEN OF WHAT COUNTRY? U S		
13a. FATHER'S NAME Butler Click			13b. MOTHER'S MAIDEN NAME Catherine Nichols			14. NAME OF HUSBAND OR WIFE Mamie Click			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. X X no		17. INFORMANT'S SIGNATURE OR NAME Mrs Mamie Click			ADDRESS Salem Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage					5 days		
		ANTECEDENT CAUSES							
		MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 1-16 1949, to 7-18, 1949, that I last saw the deceased alive on 7-21, 1949, and that death occurred at 4:30 P.M., from the causes and on the date stated above.									
23a. SIGNATURE: M. M. Hart M.D.				23b. ADDRESS Salem Mo.		23c. DATE SIGNED July 23-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 7/24/49		24c. NAME OF CEMETERY OR CREMATORY Cedar Grove		24d. LOCATION (City, town, or county) Salem Mo (State)			
DATE REC'D BY LOCAL REG. July 23-49		REGISTRAR'S SIGNATURE M. M. Hart M.D. 83		25. FUNERAL DIRECTOR'S SIGNATURE Charles Spencer		ADDRESS Salem Mo			

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

9770 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED 7-25-49  
District Health Officer No. 5,  
District File Number 749544  
Date Filed 7-25-49

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.

Student .....  
Student Embalmer

Signed Carl H. Johnson

Licensed Embalmer No. 370

P. O. Address Salmon, Wt.

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.