

THE DIVISION OF HEALTH OF MISSOURI

FILED SEP 26 1949 STANDARD CERTIFICATE OF DEATH

State File No. 32737

BIRTH NO. REG. DIST. NO. 340 PRIMARY REG. DIST. NO. 4503 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY <b>STODDARD</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>STODDARD</b>		
b. CITY (If outside corporate limits, write RURAL and give township) <b>BERNIE</b>		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) <b>BERNIE</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>HOME</b>			d. STREET ADDRESS (If rural, give location)		

3. NAME OF DECEASED a. (First) <b>VINA</b> b. (Middle) <b>CLARK</b> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <b>June 27 1949</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE 7, 1896</b>	9. AGE (In years last birthday) <b>53</b>	IF UNDER 1 YEAR Days <b>20</b> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS, OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Charley Clark</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Raymond Clark Bernie, Mo.</b>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cancer of Rectum</b>		II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.			<b>Unknown</b>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b)			
		DUE TO (c)			

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 Jan 22, 1944 to June 27, 1949, that I last saw the deceased alive on June 27, 1949, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>F O Kelley, D.O.</b>		23b. ADDRESS <b>Bernie, Mo</b>		23c. DATE SIGNED <b>7-2-49</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>6/29/49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bernie Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Bernie, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>9-7-1949</b>		REGISTRAR'S SIGNATURE <b>Patricia V. Jenkins</b>		FUNDING DIRECTOR'S SIGNATURE ADDRESS <b>1409 S. Jackson St. Bernie Mo.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED SEP 15 1919

District Health Office No. 2,

District File Number 944-916

Date Filed \_\_\_\_\_

**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 J. G. Schaefer

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4086

P. O. Address Moedun

**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.