

FILED AUG 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29227

BIRTH NO. _____ REG. DIST. NO. 130 PRIMARY REG. DIST. NO. 1112 Registrar's No. 12

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY SCOTT | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY SCOTT | |
| b. CITY (If outside corporate limits, write RURAL and give township) KELSO | c. LENGTH OF STAY (In this place) 2 mos. | c. CITY (If outside corporate limits, write RURAL and give township) KELSO 1000 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION AT HOME | | d. STREET ADDRESS (If rural, give location) 0 | |

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|--|---------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) DIANNE b. (Middle) LYNN c. (Last) CLARK | | | 4. DATE OF DEATH (Month) (Day) (Year) AUG 6 1951 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | 8. DATE OF BIRTH APRIL 8-1951 | | 9. AGE (In years, last birthday) Months Days Hours Min. 2 28 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHELO | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) SOUTH DAKOTA | | 12. CITIZEN OF WHAT COUNTRY? USA. |

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| 13a. FATHER'S NAME WOODROW P. CLARK | 13b. MOTHER'S MAIDEN NAME VERNA EIFERT | 14. NAME OF HUSBAND OR WIFE |
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| 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. NONE | 17. INFORMANT'S SIGNATURE OR NAME MRS. VERNA EIFERT | ADDRESS KELSO |
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| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis | | INTERVAL BETWEEN ONSET AND DEATH 1 week |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Spina B. fluida | | |
| | DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 751X |
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| | | |
|--|--|---------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 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 July 4, 1951, to Aug 6, 1951, that I last saw the deceased alive on Aug 4, 1951, and that death occurred at 4 P. M., from the causes and on the date stated above.

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|--------------------------------------|-------------------|-----------------------------------|----------------------------|
| 23a. SIGNATURE W. A. Steyer, M.D. | (Degree or title) | 23b. ADDRESS Capel Guard No. 2 | 23c. DATE SIGNED 8-6-51 |
|--------------------------------------|-------------------|-----------------------------------|----------------------------|

| | | | |
|---|-----------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE AUG 8/51 | 24c. NAME OF CEMETERY OR CREMATORY ST AUGUSTINE'S | 24d. LOCATION (City, town, or county) (State) KELSO, MO |
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|-------------------------------------|------------------------------|--|-----------------------|
| DATE REC'D BY LOCAL REG. 8-19-51 | REGISTRAR'S SIGNATURE 300 | 25. FUNERAL DIRECTOR'S SIGNATURE Burling Coff. Funeral Home | ADDRESS Illmo. Mo. |
|-------------------------------------|------------------------------|--|-----------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 20 1951
SCOTT COUNTY HEALTH CENTER
CO. FILE NO. 851-184

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 Arthur P. Amick

Licensed Embalmer No. 4470

P. O. Address Illinois, 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.