

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3869

State File No.

FILED MAR 3 1952

REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 4009 Registrar's No. 18

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

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SAVANNAH</u>		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Dr. Nichols Sanatorium</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Abinodon</u> <u>8120</u>	
		d. STREET ADDRESS (If rural, give location) <u>8</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>BAYLOR</u> c. (Last) <u>CLARK</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>28</u> <u>52</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u> <u>2</u>	8. DATE OF BIRTH <u>10-25-1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Not Known</u>	9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR Months <u>4</u> IF UNDER 11 HRS. Days <u>3</u> Hours Min.
11. BIRTHPLACE (State or foreign country) <u>9</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>John Clark</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda L. Jones</u>	14. NAME OF HUSBAND OR WIFE <u>Mila Olive Rindler</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Florence Linkham Morris Clark</u>
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastric Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Decaying</u> DUE TO (c) <u>Pleural effusion</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of face & under jaw glands. 1 1/2 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of face & under jaw glands.</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? <u>1981</u>	
22. I hereby certify that I attended the deceased from <u>Feb 22</u> , 1952, to <u>Feb 28</u> , 1952, that I last saw the deceased alive on <u>Feb 28</u> , 1952, and that death occurred at <u>4</u> p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>H. S. ... M.D.</u>		23b. ADDRESS <u>Savannah Mo</u>	23c. DATE SIGNED <u>2-28-52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>2-28-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Not Known</u>	24d. LOCATION (City, town, or county) (State) <u>Abinodon Ill.</u>
DATE REC'D BY LOCAL REG. <u>2-28-52</u>	REGISTRAR'S SIGNATURE <u>L. L. Sparks</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Breit Funeral Home SAVANNAH Mo</u>	

11-15-58

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

E. B. Breit

Licensed Embalmer No. *2650*

P. O. Address *Scranton 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.