

FILED JAN 30 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **254**

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BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY Buchanan b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph c. LENGTH OF STAY (In this place) most of life d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION D.O.A. Missouri Methodist Hospital;		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan c. CITY OR TOWN St. Joseph d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) Mertland Apartments.	
3. NAME OF DECEASED (Type or Print) a. (First) Marie b. (Middle) — c. (Last) Clarke		4. DATE OF DEATH (Month) (Day) (Year) January 15th 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 31, 1880
9. AGE (In years last birthday) 75 Yrs IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 14 HRS: Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) Corydon, Iowa 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
13a. FATHER'S NAME Benjamin Hillyard		13b. MOTHER'S MAIDEN NAME Mary Jane Haskell	
14. NAME OF HUSBAND OR WIFE Samuel Clarke		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Elliott C. Spratt, ADDRESS 706 South 13th	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION St. Joseph, Mo. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary edema ANTECEDENT CAUSES DUE TO (b) Coronary occlusion DUE TO (c) signed as an unattended death II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. in city of St. Joseph, Mo.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201	
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) (Min.) _____ 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 viewed the deceased from <u>1-16</u>, 19<u>56</u>, to _____, 19____, that I found the deceased <u>alive on _____, 19____, and that death occurred at <u>10:40pm</u>, from the causes and on the date stated above.</u> <i>signed after exam.</i> 			
23a. SIGNATURE (Degree or title) Richard L. Maguire M.D. assistant chief health officer		23b. ADDRESS 1302 Salmon St., City 23c. DATE SIGNED 1-16-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) (Burial)		24b. DATE Jan. 18, 1956 24c. NAME OF CEMETERY OR CREMATORY Fulton Mortuary 24d. LOCATION (City, town, or county) (State) Kansas City, Kansas.	
DATE REC'D BY LOCAL REG. Jan 23, 1956		REGISTRAR'S SIGNATURE Robert M. Allison 25. FUNERAL DIRECTOR'S SIGNATURE 485-0 Meierhoffer ADDRESS St. Joseph, Mo.	

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.....
Signature of Student Embalmer

Signed *Albert B. Harrington*

Licensed Embalmer No....3258...

P. O. Address...St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.