

FILED JUL 23 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22835

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 780

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (in this place) <u>4 mos-10 days</u>	c. CITY OR TOWN <u>Sheridan</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #2</u>		e. STREET ADDRESS (If rural, give location) <u>Rural, East Nodaway</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>ULYSSES</u> b. (Middle) <u>GRANT</u> c. (Last) <u>CLARK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 17, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 8, 1886</u>
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 Wks. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Nodaway County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Alexander Clark</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarelda Michael</u>		14. NAME OF HUSBAND OR WIFE <u>Ruth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ruth Clark, Sheridan, Mo.</u>		ADDRESS _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>decompensated heart chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
ANTECEDENT CAUSES DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>psychotic</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4500	
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 <u>7/17</u> , 19 <u>56</u> , to <u>7/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/17</u> , 19 <u>56</u> , and that death occurred at <u>5:30p. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>G.E. Gossius M.D.</u>		23b. ADDRESS <u>State Hosp. #2, St. Joseph, Mo.</u>	
23c. DATE SIGNED <u>7/17/56</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	
24b. DATE <u>7/17/56</u>		24c. NAME OF CEMETERY OR CREMATORY _____	
24d. LOCATION (City, town, or county) (State) <u>Grant City, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS _____	
DATE REC'D BY LOCAL REG. <u>July 19, 1956</u>		REGISTRAR'S SIGNATURE <u>Heather M. Allison</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Heaton Bowman</u>		ADDRESS <u>St. Joseph, Mo.</u>	

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

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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.....
Licensed Embalmer No. 4535
P. O. Address 3195 10th St

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.