

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7835

State File No. ....

FILED MAR 27 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 44 PRIMARY REG. DIST. NO. 4060 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>CALDWELL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>LIVINGSTON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BRECKENRIDGE</u>		c. CITY OR TOWN <u>LUDLOW</u>	
c. LENGTH OF STAY (In this place) <u>50 years</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>HOMER</u>		e. STREET ADDRESS (If rural, give location) <u>RURAL</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u> b. (Middle) <u>MARTHA</u> c. (Last) <u>CLARK</u>	4. DATE OF DEATH <u>MARCH 12-1957</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 4-1866</u>	9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>8</u>	IF UNDER 24 HRS. Days <u>8</u>	IF UNDER 1 MIN. Hours <u>8</u>	IF UNDER 1 MIN. Min. <u>8</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Keokuk, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>LEWIS FITZPATRICK</u>	13b. MOTHER'S MAIDEN NAME <u>AMY TONER</u>	14. NAME OF HUSBAND OR WIFE <u>JAMES CLARK DECEASED</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Clay Clark</u>	ADDRESS <u>Ludlow, Mo.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Renal insufficiency</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
*This does not mean the mode of dying, such as heart failure, asthenia, 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) <u>Metastatic Carcinoma</u> <u>1-2 yrs</u>	
		DUE TO (c) <u>Carcinoma unknown</u> <u>7 yrs</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>153X</u>	20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 11-1, 1956, to 3-12, 1957, that I last saw the deceased alive on 3-12, 1957, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Buckley Fleming MD</u>	23b. ADDRESS <u>Buckinridge Mo</u>	23c. DATE SIGNED <u>3-17-57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>MARCH 14-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>TONER</u>	24d. LOCATION (City, town, or county) (State) <u>Ludlow Mo</u>
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DATE REC'D BY LOCAL REG. <u>3-16-1957</u>	REGISTRAR'S SIGNATURE <u>Mr. Rob Ann... Jorgart</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>DICKERSON FUNERAL HOME</u>	ADDRESS <u>Boquoy</u>
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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.....  
*R. M. Marshall Jr.*

Licensed Embalmer No. *4469*

P. O. Address *Carrollton, Va.*

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.