

with, & Welfare Public Service

FILED MAY 5 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017058
STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 6183 Registrar's No. 62

300
1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Sullivan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Milan		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Browning		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sullivan Co Rest Home		Length of stay in 1b		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence Middle Last Clarkson				4. DATE OF DEATH Month 4 Day 22 Year 58			
5. SEX fe	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1875		9. AGE (In years (Monthday)) 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? 0	
13a. FATHER'S NAME A. D. Clarkson			13b. MOTHER'S MAIDEN NAME Mary Nelson			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Nate Clarkson 5310 Norlidge Kansas City, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 6 hr	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____							
DUE TO (c) _____						331X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Milan Sullivan		COUNTY Mo STATE	
21. I attended the deceased from 4/22/58 , to 4/22/58 and last saw her/him alive on 4/22/58 Death occurred at 8P.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Joseph S. Michael MD (Degree or title)				22b. ADDRESS Milan Mo		22c. DATE SIGNED 4/24/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/24/58	23c. NAME OF CEMETERY OR CREMATORY Jenkins Cem		23d. LOCATION (City, town, or county) (State) Browning, Mo.		
24. FUNERAL DIRECTOR Wade Funeral Home			ADDRESS Browning, Mo		25. DATE RECD. BY LOCAL REG. 4-28-58		26. REGISTRAR'S SIGNATURE Mrs. M. W. Beckett

(Licensed Embalmer's Statement on Reverse Side)

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 *Gerald I. Wood*

Licensed Embalmer No. *4172*
P. O. Address *Brown*

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.