

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031629
STATE FILE NUMBER

REGISTRATION DISTRICT NO. 10 PRIMARY REGISTRATION DISTRICT NO. 3002 REGISTRAR'S NO. 190
SEP 25 1958

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mexico</u> <u>0043</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain Hospital</u>		Length of stay in lb <u>15 days</u>	d. STREET ADDRESS (If outside, give location) <u>322 W. Maple</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Telitha</u> Last <u>Clark</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1874</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Callaway County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>James K.P. Scott</u>	13b. MOTHER'S MAIDEN NAME <u>Susan Telitha McNich</u>	14. NAME OF HUSBAND OR WIFE <u>Arthur Clark</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Gilbert Saylor</u> Address <u>Mexico, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial decompression</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial degeneration</u>	<u>5 yrs.</u>
	DUE TO (c) <u>Hypertensive heart disease</u>	<u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443X</u>		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.)
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20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <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 COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from <u>9-8-58</u> to <u>9-15-58</u> and last saw her alive on <u>9-15-58</u> Death occurred at <u>2:25 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>R.H. Swan</u> (Degree or title) <u>LOD 2</u>	22b. ADDRESS <u>Grand Ave</u>	22c. DATE SIGNED <u>9-18-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-19-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Auxvasse Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Callaway County Missouri</u>
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24. FUNERAL DIRECTOR <u>Arnold Funeral Home Mexico, Mo.</u>	ADDRESS <u> </u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 18-1958</u>	26. REGISTRAR'S SIGNATURE <u>Bonnie Geely</u>
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All diseases in Part I must be causally related.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
 MEDICAL CERTIFICATION
 P. 19 SWAN 430
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

APR 28 1959

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 *Ray Miller*

Licensed Embalmer No. *7495*

P. O. Address *Medford*

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.