Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008460
STATE FILE NUMBER

APR 6 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 331

1. PLACE OF DEATH a. COUNTY Buchanan	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buch.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Joseph c11 ? — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Mo.Meth. Hosp. — Length of stay in 1b 8 days	d. STREET ADDRESS (If outside, give location) 516th S. 15th., — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First Delia Middle - Last Clinkinbeard		4. DATE OF DEATH Month Day Year Mar. 27, 1959	
5. SEX Female 1	6. COLOR OR RACE White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]	8. DATE OF BIRTH Apr.2,1861
9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Sidney Long	13b. MOTHER'S MAIDEN NAME Abi Parker	14. NAME OF HUSBAND OR WIFE Alfred M.Clinkinbeard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs.Grace Porter, Address Savannah,Missouri	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Thrombosis	11 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral Vascular Disease	?
DUE TO (c)	Osteo Arthritis	10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Mar-17-59, to Mar-27-59 and last saw her/him alive on Mar-27-59
Death occurred at 11:00 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) T. L. Howden M.D.	22b. ADDRESS 419 Kirkpatrick Bldg	22c. DATE SIGNED 3-30-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar.30,1959	23c. NAME OF CEMETERY OR CREMATORY Goshen
23d. LOCATION (City, town, or county) Princeton (State) Missouri		
24. FUNERAL DIRECTOR Roland D Clark ADDRESS King City Mo	25. DATE RECD. BY LOCAL REG. April 2, 1959	26. REGISTRAR'S SIGNATURE Mrs Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Dr. T. L. Howden

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Roland D. Clark

Licensed Embalmer No. 4477.

P. O. Address King City 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.