

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017651

STATE FILE NUMBER

FILED JUN 9 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

2476

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen. Hospital</b>		Length of stay in 1b <b>69 YRS.</b>	d. STREET ADDRESS <b>8319 Wayne</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WINOHA</b> Middle <b>WINOHA F.</b> Last <b>Clark E.</b>			4. DATE OF DEATH Month <b>5</b> Day <b>17</b> Year <b>59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>3</b> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 22 1890</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>IF UNDER 24 HRS.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRACTICAL</b>	11. BIRTHPLACE (City and state or country) <b>KANSAS CITY, MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>THOMAS GIBBONS</b>		13b. MOTHER'S MAIDEN NAME <b>IDD MAE HOVERSTOCK</b>		14. NAME OF HUSBAND OR WIFE <b>GEORGE CLARKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>495 20 9797</b>	17. INFORMANT Address <b>MARVEL HUPP 8319 WAYNE KANSAS CITY, MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the cervix with metastasis</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
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 checked="" type="checkbox"/> NO <input 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.) <b>171X</b>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
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 STATE	
21. I attended the deceased from <b>5-13-59</b> to <b>5-17-59</b> and last saw her alive on <b>5-17-59</b> Death occurred at <b>1:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Abraham Gelperin</b>			22b. ADDRESS <b>General Hospital</b>		22c. DATE SIGNED <b>5-19-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>MAY 19, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN, CEM</b>		23d. LOCATION (City, town, or country) (State) <b>KANSAS CITY, MO.</b>	
24. FUNERAL DIRECTOR <b>D.W. McNamee's Son, MO</b>		ADDRESS <b>K.C.</b>	25. DATE RECD. BY LOCAL REG. <b>5-19-59</b>	26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>	

(Licensed Embelmer's Statement on Reverse Side)

Health, Welfare, Public Service

100-57

All diseases in Part I must be causally related.

Abraham Gelperin, M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Albert L. Savage* .....

Licensed Embalmer No. *4812* .....

P. O. Address *Kansas 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.