

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021268

FILED JUN 17 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER Registrar's No. 2658

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>Cass</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>BELTON</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>V A HOSPITAL</b>		Length of stay in lb <b>15 days</b>	d. STREET ADDRESS (If outside, give location) <b>GREEN VALLEY TRAILOR COURT</b>		Reside on Farm <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>WILLIAM</b> Last <b>CLARK</b>			4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1933</b>	9. AGE (In years last birthday) <b>26</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Essex, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>2 U.S.A.</b>
13a. FATHER'S NAME <b>Dave Robert Clark</b>		13b. MOTHER'S MAIDEN NAME <b>Alice Rice</b>		14. NAME OF HUSBAND OR WIFE <b>Joan Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 4-8-52 to 12-30-58</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>VA Hospital Official Records, K. C. 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>Metastatic, to lungs, malignant melanoma</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
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) <b>1909</b>					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 _____ 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 COUNTY STATE	
21. <input checked="" type="checkbox"/> attended the deceased from <b>May 13, 1959</b> to <b>May 28, 1959</b> Death occurred at <b>11:15</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>C. S. Andrews, M.D.</b>			22b. ADDRESS <b>VA Hosp</b>		22c. DATE SIGNED <b>5-28-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>MAY 30, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WINNEBAGO CEM</b>		23d. LOCATION (City, town, or county) (State) <b>WINNEBAGO, MINN</b>
24. FUNERAL DIRECTOR <b>W W Newcome's Son</b>		ADDRESS <b>K.C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-29-59</b>	26. REGISTRAR'S SIGNATURE <b>Newcomer</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

746

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 *Chester K Brown* .....

Licensed Embalmer No. *4931* .....

: P. O. Address *KE 22* .....

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.