

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-028890

## FILED VS AUG 17 1959

STATE FILE NUMBER

 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 95

IDEB

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howell</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains minutes</u> Length of stay in lb <u>minutes</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Stoll Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u> c. CITY OR TOWN <u>Lacomo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Grace</u> Middle <u>Elmora</u> Last <u>Clark</u>				<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>20</u> Year <u>59</u>													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Wht.</u>		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12-6-1888</u>		<b>9. AGE (last birthday)</b> <u>76</u>		<b>IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>12</u>		<b>IF UNDER 24 HR</b> Hours <u></u> Min. <u></u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u>				<b>11. BIRTHPLACE</b> (City and state or country) <u>South Park Mo.</u>				<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>					
<b>13a. FATHER'S NAME</b> <u>Ashley Pritchey</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Lenthurim</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>G. C. Clark</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u></u>				<b>17. INFORMANT</b> <u>G. C. Clark</u> Address <u>Lacomo Mo.</u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Diabetor</u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)													
<b>20c. TIME OF INJURY</b> Hour <u></u> Month, Day, Year <u></u>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)				<b>20f. CITY, TOWN, OR LOCATION</b>				<b>COUNTY</b>				<b>STATE</b>					
<b>21. I attended the deceased from</b> <u>5-9-54</u> to <u>7-20-59</u> and last saw her/him alive on <u>7-20-59</u> Death occurred at <u>10:40 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.																	
<b>22a. SIGNATURE</b> <u>G. C. Clark M.D.</u> (Degree or title)						<b>22b. ADDRESS</b> <u>West Plains Mo.</u>						<b>22c. DATE SIGNED</b> <u>8-13-59</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>B</u>				<b>23b. DATE</b> <u>7-28-59</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Death Park</u>				<b>23d. LOCATION</b> (City, town, or county) (State) <u>South Park Mo.</u>					
<b>24. FUNERAL DIRECTOR</b> <u>Robertson</u> ADDRESS <u>West Plains Mo.</u>						<b>25. DATE RECD. BY LOCAL REG.</b> <u>8-13-59</u>						<b>26. REGISTRAR'S SIGNATURE</b> <u>Beatrice Cook</u>					

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W. Robertson

Licensed Embalmer No. 343

P. O. Address West Pl

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.