

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 4 1959

59-038821

STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 234

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Length of stay in 1b <u>18 yrs.</u>	c. CITY OR TOWN <u>Mexico</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>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>803 S. Muldrow</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>ALVA</u> Last <u>CLARK</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1959</u>		
--	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 75</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____
------------------------------	---	--	---	--	---	-------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Fredericktown, Ind.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	---	---

13a. FATHER'S NAME <u>William Clark</u>	13b. MOTHER'S MAIDEN NAME <u>Hanna McClaran</u>	14. NAME OF HUSBAND OR WIFE <u>Daisie Clark</u>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>491-07-2687</u>	17. INFORMANT Address <u>Mrs. Daisie Clark, Mexico, Mo.</u>
--	--	---

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) <u>Chronic Degenerative Myocarditis with Auricular Fibrillation - and congestive Failure</u>		<u>6 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Failure</u>	<u>1 month</u>
	DUE TO (c) <u>Cerebral Thrombosis Right lateral with partial paralysis</u>	<u>11-2-59</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis - Coronary</u>	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
--	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>X</u>
--	---	---

20c. TIME OF INJURY Hour _____ Minute _____	Month, Day, Year <u>11-30-59</u>
---	-------------------------------------

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>X</u>	20f. CITY, TOWN, OR LOCATION <u>X</u>	COUNTY _____ STATE _____
---	---	---	--------------------------

21. I attended the deceased from 6-20-59 **to** 11-30-59 **and last saw her/him alive on** 11-29-59
Death occurred at 11-30-59 1:50 **pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Harry F. O'Brien MD</u>	(Degree or title)	22b. ADDRESS <u>Mexico, Mo.</u>	22c. DATE SIGNED <u>11-30-59</u>
---	-------------------	---	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 2, 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	23d. LOCATION (City, town, or county) <u>Moberly, Mo.</u>	(State)
---	---------------------------------------	---	---	---------

24. FUNERAL DIRECTOR <u>Precht-Hueston</u>	ADDRESS <u>Mexico, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 1-1959</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>
--	-------------------------------	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 16 1960

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 Thomas M. Emmons Jr

Licensed Embalmer No. 5064

P. O. Address: Mexico, 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.