

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 28 1960

60-012015

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 124

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Length of stay in 1b <u>50 Yrs.</u>	c. CITY OR TOWN <u>Sedalia</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>Bothwell Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>217 W. Morgan St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wyatt Alexander Clark</u>			4. DATE OF DEATH Month Day Year <u>March 17 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/21/86</u>	9. AGE (last birthday) <u>73 yrs.</u>
IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor (ret.)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	11. BIRTHPLACE (City and state or country) <u>Bowling Green, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Wyatt Clark</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Harrington</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Bessie 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>none</u>	17. INFORMANT Address <u>Mrs. Bessie Clark Sedalia, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiovascular disease unknown</u> DUE TO (c) <u>Arteriosclerosis - Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Interstitial Nephritis</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 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 Month, Day, Year 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 <u>2-29-60</u> to <u>3-17-60</u> and last saw him alive on <u>3-17-60</u> Death occurred at <u>3-17-60</u> <u>6:17</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>A. R. Maddox M.D.</u>			22b. ADDRESS <u>Sedalia Mo</u>		22c. DATE SIGNED <u>3-17-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 21, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crownhill Annex Cem.</u>	23d. LOCATION (City, town, or county) <u>Sedalia, Mo.</u>		
24. FUNERAL DIRECTOR <u>Francis Shelby</u>		ADDRESS <u>400 W Loop</u>	25. DATE RECD. BY LOCAL REG. <u>3-21-1960</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>	

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 *Eric Alfano*

Licensed Embalmer No. 424

P. O. Address *Seaside*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.