

**FEDERAL BUREAU OF INVESTIGATION**  
**DEPARTMENT OF JUSTICE**  
**U. S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**EILED VS MAY 17 1960**

**=60-018206**

STATE FILE NUMBER

Registration District No. 002 Primary Registration District No. 4009 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <b>ANDREW</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>ANDREW</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SAVANNAH</b>		Length of stay in 1b	c. CITY OR TOWN <b>SAVANNAH</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>417 North Third St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>417 North Third St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERTHA CLARK</b>			4. DATE OF DEATH Month Day Year <b>May 8, 1960</b>		
5. SEX <b>female</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>10-11-78</b>	9. AGE (last birthday) <b>81</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>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Andrew County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>Lyman Holcomb</b>		13b. MOTHER'S MAIDEN NAME <b>Cassie Wilson</b>		14. NAME OF HUSBAND OR WIFE <b>Charles C. Clark</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>- - -</b>		17. INFORMANT Address <b>Charles C. Clark, Savannah, 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>Cerebral-vascular accident</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 years</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 (e)				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 a.m. p.m. Month, Day, Year					
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>May 17, 1959</b> to <b>May 8, 1960</b> and last saw <b>her</b> alive on <b>May 8, 1960</b> Death occurred at <b>5:30 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Warren C. Baker M.D.</i>		22b. ADDRESS <b>Savannah, Missouri</b>		22c. DATE SIGNED <b>5-10-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>May 10, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cemetary</b>		23d. LOCATION (City, town, or county) (State) <b>Savannah, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>BREIT &amp; HAWKINS SAVANNAH</b>		25. DATE RECD. BY LOCAL REG. <b>5-14-60</b>	26. REGISTRAR'S SIGNATURE <i>Lillian Sparks</i>		

(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

*James B. Hawkins*

Licensed Embalmer No. 4536

P. O. Address Savannah

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