

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED 21 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

35646
Do not use this space.

1. PLACE OF DEATH
 (a) County Callaway 3 Registration District No. 104
 (b) Township Fulton 1 Primary Registration District No. 3008 Registered No. 282
 (c) City Fulton (d) Street No. State Hospital #1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Abbie Clark
 (a) Residence, No. Clarksburg, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL 4 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 6 6

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clarksburg, Mo.

FATHER
 13. NAME John W Clark
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

MOTHER
 15. MAIDEN NAME FRANCIS BROWN
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Hospital Records

18. BURIAL, CREMATION, OR REMOVAL PLACE Clarksburg Mo DATE 10/17 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) William Fredmeyer California Mo

20. FILED Oct. 11 1939 U. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 10 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 13 1939 to Oct. 10 1939
 I last saw her alive on Oct. 10 1939 Death is said to have occurred on the date stated above, at 9:15 A.M.
 The principal cause of death and related causes of importance were as follows:
Arteriosclerotic Heart Disease
 Other contributory causes of importance: as b

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide: NO Date of injury, 19
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO
 If so, specify
 (Signed) Geo. J. Wood, M. D.
 (Address) State Hospital #1 Fulton Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.