CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

File No. 27112

PLACE OF DEATH

County of Ray

Township 52 Fishing River Registration District No. 743

or

Village Near Orrick Mo. Primary Registration District No. 6237 Registered No. 22

or

City ..... (No. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ephraim Clark

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	M

DATE OF BIRTH Feb 8 — (Month) (Day), 1818 (Year)

AGE 96 yrs. 8 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Mason

BIRTHPLACE (City or town, State or foreign country) Ray County Mo.

PARENTS

NAME OF FATHER Rausley Clark

BIRTHPLACE OF FATHER (City or town, State or foreign country) — — —

MAIDEN NAME OF MOTHER — — —

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ray Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. P. Clark

(ADDRESS) Orrick Mo

Filed Aug 14, 1914 L. E. Ellis REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 13 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from April 2, 1914, to Aug 13, 1914, that I last saw h alive on July 22, 1914, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

93D 79

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (SECONDARY) Senile other diseases (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) L. E. Ellis M. D.

Aug 14 1914 (Address) Orrick Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL Rowland Cemetery DATE OF BURIAL Aug 14 1914

UNDERTAKER F. S. Rowland ADDRESS Orrick Mo

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward)

[If death occur hospital or in give its NAME of street and nu

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

Revised United States Standard Certificate

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH

..... (Month) ..... (Day) ..... (Year)

AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... 191... ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day)

I HEREBY CERTIFY, that I attended deceased

....., 191..., to....., 1

that I last saw h..... alive on....., 1

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory (SECONDARY) .....

.....(Duration).....yrs.....mos.....

(Signed) .....

....., 191... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIEN RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS