No. 2
I—8-43
5-17-39
I X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24800

FILED JUL 14 1945

Registration District No. [illegible] Primary Registration District No. 6022 Registrar's No. 47.

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Richmond Twns
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ray 89
(c) City or town Richmond, Mo. Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 4 Miles North 0
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Samuella Clark
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John B. Clark
6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased Aug. (Month) 30. (Day) 1866 (Year)

8. AGE: Years	Months	Days	If less than one day
79	11	20	hr. min.

9. Birthplace Turant Co. (City, town, or county) Texas (State or foreign country)
10. Usual occupation House Wife
11. Industry or business

MOTHER
12. Name Wm. King McGee
13. Birthplace Unknown (City, town, or county) Mo. 0 (State or foreign country)

FATHER
14. Maiden name Sarah Jane Wagner
15. Birthplace Unknown (City, town, or county) Ind. (State or foreign country)

16. (a) Informant Jesilee Clahk
(b) Address Richmond Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23 1945 (Month) (Day) (Year)
(c) Place burial or cremation Richmond. Mo.
18. (a) Signature of funeral director E Burman
(b) Address Richmond. Mo.
19. (a) 7/21 45 (Date received local registrar) (b) Mrs Chas W Shippey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 1945 hour 10 minute P M.
21. I hereby certify that I attended the deceased from July 14, 1945, to July 20—45, 19; that I last saw her alive on July 20—45, 19; and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death Fractured hip.	
Due to Fall.	
Due to	
Other conditions Chronic gall bladder infect. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 89
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature L D Freels (M. D. or other)
Address Richmond Mo. Date signed 7-21-45

1280 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-13-45

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

Signed E. Thurman

Licensed Embalmer No. 2073

P.O. Address Richmond, 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 this body is not embalmed, fact should be so stated above.

No. 2B
M—3-45
I X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI.

STANDARD CERTIFICATE OF DEATH

REC'D AUG 14 1945

State File No. 1945

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 47

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Richmond Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Samuella Clark

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 26 (Day) 1865 (Year)

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Texas (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1945 hour 1 minute M.

21. I hereby certify that I attended the deceased from , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident,

(b) Date of occurrence July 14 1945,

(c) Where did injury occur? Richmond (City or town) Ray (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home, on farm, (Specify type of place)

While at work? No (e) Means of injury Fall,

23. Signature [illegible] (M. D. or other)

Address Richmond Mo. Date signed [illegible]

SUPPLEMENTARY

S-24800