

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

Do not use this space.

20917

1. PLACE OF DEATH **U.S.V.Hosp. #67**

County.....**Jackson**.....

Registration District No.....

File No.....**2799**.....

Township.....**Kaw**.....

Primary Registration District No.....

Registered No.....

City.....**Kansas City, Mo.**..... (No. **U.S. Veterans Hospital**)

St. .... Ward)

2. FULL NAME **CLIFFORD, Benedict Joseph**

**Pvt. Co F 5th Dev. Bn.**

(a) Residence. No. **510 W 11th St.**

Ward. **1**

(If nonresident give city or town and State)

(Usual place of abode) **Kansas City, Missouri.**

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>Single</b>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 19, 1897**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<b>31</b>	<b>2</b>	<b>9</b>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Clerk**

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **New York**

10. NAME OF FATHER **Unknown**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

14. Informant **Hospital Records.**

(Address) **Kc Mo**

15. FILED **6-30-28 M M Craive** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 28 19 28**

17. I HEREBY CERTIFY, That I attended deceased from **December 23 19 28** to **June 28 19 28**

that I last saw him alive on **June 28 19 28**, and that death occurred, on the date stated above, at **5:45 A.M.** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Pneumonia, lobar, right lung**

**108**  
**1010**  
..... yrs. .... mos. **3** ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, **U.S. Veterans' Hosp. #67**

DID AN OPERATION PRECEDE DEATH. **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS. **Physical examination.**

(Signed) **W.E. Chambers**, M.D.  
**W.E. CHAMBERS, Medical Officer in Charge**  
**H.S. Veterans Hosp. Kansas City, Mo.**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

**Leavensworth Kans July 2 19 28**

20. UNDERTAKER ADDRESS **A. J. DEHNER MORTUARY City**

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.

