

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

Do not use this space
Fullbright
12504

MAY 26 1930

1. PLACE OF DEATH
County Greene Registration District No. 318
Township _____ Primary Registration District No. 200A
City Springfield (No. St. John's Hospital)
St. _____ Ward _____

2. FULL NAME Ray A. Clifton
(a) Residence. No. Beige, Okla. St. _____ Ward _____
(Usual place of abode) (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.

File No. _____
Registered No. 303
St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 4, 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 7 8

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer (driller)
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Langhams (STATE OR COUNTRY) Nebr.

10. NAME OF FATHER Chas. Clifton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Nebr. (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Emma Crocker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) N.Y. (STATE OR COUNTRY) _____

14. INFORMANT Mother, Mrs. Emma Hickey
(Address) Rt. 8, Springfield, Mo.

15. FILED 4-15-30 John Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12, 1930
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 5:45 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Urna
resulting
132B
from
General debility
CONTRIBUTORY (SECONDARY) _____

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chemical exam
(Signed) H. Fullbright, M. D.
4/14, 1930 (Address) Springfield, 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 Forest Home DATE OF BURIAL April 17, 1930
20. UNDERTAKER John Sharp ADDRESS Springfield, Mo
Funeral Home

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.

