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

REC'D OCT 15 1938

31184
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Raw
(c) City K.C. Mo
Registration District No. 399
Primary Registration District No. 1002
Registered No. 3481
(d) Street No. K.C. Gen Hospt 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Clifton C Dalrymple
(a) Residence, No. 3040 Forest St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
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) Nov-2-1886

7. AGE: 52 YEARS; 10 MONTHS; 1 DAYS; If LESS than 1 day, ...hrs. or ....min.

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 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mich

FATHER
13. NAME unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER
15. MAIDEN NAME unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Record Clerk K.C. Gen Hospt

18. ~~BURIAL~~, CREMATION, ~~OR REMOVAL~~
PLACE Mt Merwegner DATE 9-5-38

19. FUNERAL DIRECTOR (NAME) Peter B. Kopelman
(ADDRESS) 536 Campbell St

20. FILED Sept 5 1938 M. M. Crow
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-3-38 19

22. I HEREBY CERTIFY, That I attended deceased from Sept 2- 1938 to Sept 3-1938
I last saw him alive on Sept-3-1938. Death is said to have occurred on the date stated above, at 3:30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral sclerosis	
Encephalomalacia	
Chronic Vascular Nephritis	

Other contributory causes of importance:

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... 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? .....
If so, specify .....

(Signed) Geo. A. Mason, M.D.
(Address) Sept K.C. Gen Hospt K.C. Mo

Licensed Embalmer's Statement on Reverse Side)

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

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 co with the above constitutes grounds for revocation of license.)

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township — Primary Registration District No. 1002 — Registered No. 3481
(c) City K. C. — (d) Street No. ..... 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Clifton C. Dalrymple (Correct)
(a) Residence, No. ..... 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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
52	10	1	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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

17. INFORMANT (ADDRESS)

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

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9/5, 1938 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-3, 1938

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

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? ..... 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? .....
If so, specify .....
(Signed) P. F. Denning, M. D.
(Address) Suff. Gen. Hosp. K. C. Mo.

SUPPLEMENTARY

S-31184