

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 879Registrar's No. 879Registration District No. 791Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis **FILED FEB 17 1940**
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3501 Utah St.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 10 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME BARBARA E. CLIFFORD8. (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 widow
 6. (b) Name of husband or wife Jeff 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased February 3, 1872
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 11 26 hr. min.9. Birthplace Kentucky
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

12. Name Unknown
18. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Omar de Resche
(b) Address 390 2a. Monroe St.17. (a) burial (b) Date thereof 1/31/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bismarck, Missouri18. (a) Signature of funeral director Oscar J. Hoffmeister
(b) Address 4016 Chippewa Street19. (a) JAN 29 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 16
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3501 Utah St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29
year 1940 hour 11 minute 30 a. m.21. I hereby certify that I attended the deceased from Jan 25, 1940, to Jan 29, 1940
that I last saw her alive on Jan 29, 1940,
and that death occurred on the date and hour stated above.Immediate cause of death _____
Myocarditis
Broncho pneumonia 3 daDue to Sagrippe 5 daOther conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

Duration

year
3 da

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) no
 (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?

While at work? _____
(Specify type of place) (e) Means of injury _____23. Signature Ermine W Vogel (M. D. or other) MD
Address 33 25 S Grand Date signed 1/29/40

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 *Ernest W. Spillars*

Licensed Embalmer No. *14080*

P. O. Address *3528 Russell*

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, above space should be left blank.