

STANDARD CERTIFICATE OF DEATH

State File No. 32226

Registration District No. 15

Primary Registration District No. \_\_\_\_\_

Registrar's No. 5858

FILED OCT 18 1940

1. PLACE OF DEATH:

(a) County Jackson W. Va.  
(b) City or town Grandview Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wycliff Clinic  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
(Specify whether 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. 2940 Wabash  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 28  
year 1940 hour 10 minute 30 M.

21. I hereby certify that I attended the deceased from 9-28, 1940, to 9-28, 1940,  
that I last saw him alive on 9-28, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure  
Duration \_\_\_\_\_

Due to incompetence of the foramen ovale

Due to acute mitral pressure 159

Other conditions (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) \_\_\_\_\_  
(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? 366  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. E. C. Wycliff (M.D. or other) 5  
Address Grandview Mo Date signed 9-29-40

3. (a) PRINT FULL NAME Terry Edwin Clement

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. Sept 28 1940  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 8 hr. 30 min.

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name W. R. Clement

18. Birthplace Fort Scott Kansas  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Crann

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

16. (a) Informant W. R. Clement  
(b) Address 2940 Wabash, T. C. Hwy

17. (a) Burial (b) Date thereof 9/28/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Local Hills Cem.

18. (a) Signature of funeral director Mrs C. L. Grates  
(b) Address 918 Broadway, Kansas City, Mo

19. (a) 10-7-40 (b) Mrs J. S. Brennan  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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**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 comply the above constitutes grounds for revocation of license.)**

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