

Registration District No. 773

Primary Registration District No. 4464

Registrar's No. 174

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

1. PLACE OF DEATH

(a) County St. Francois
(b) City or town Farmington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether

In this community 9 years
years, months or days)

3. (a) PRINT FULL NAME Merton Clifford

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

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife James Clifford 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 2 1855
(Month) (Day) (Year)

8. AGE: Years 85 Months 8 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace St. Francois Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Home maker.

11. Industry or business _____

12. Name Egertel Smith

18. Birthplace Farmington (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant Mrs. Zona Smith

(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Smith Cemetery, St. Francois Co. Mo.

18. (a) Signature of funeral director Farmington, Mo.

(b) Address Farmington, Mo.

19. (a) Oct 1-1940 (Date received local registrar) (b) R. J. Robinson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Farmington
(If outside city or town limits, write "RURAL")

(d) Street No. West Liberty St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29
year 1940 hour ? minute A. M.

21. I hereby certify that I attended the deceased from Jan 27, 1940, to Sept 29, 1940
that I last saw her alive on Sept 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Senile dementia
Senile arteriosclerosis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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? NA

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. Applebury (M. D. or other) _____

Address Farmington Mo. Date signed 10/1/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

me....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 4084

P. O. Address Birmingham

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **32987**

Registration District No. **773**

Primary Registration District No. **4464**

Registrar's No. _____

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **St Francois**
(c) City or town **Farmington**
(If outside city or town limits, write "RURAL")
(d) Street No. **F.W. Liberty 61**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Meekie Gifford

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. _____ (Month) (Day) (Year)

8. AGE: Years **85** Months **8** Days **27** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **L.V. M. L.A. BAY SINGER**
15. Birthplace **Penna.** (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Dec 7-1940** (b) **V.B. Robinson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **29**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **Raffleberry** (M. D. or other) _____

Address **Farmington** Date _____

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

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32987

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 773

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Registrar's No. _____

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(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (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. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Neekie Giffard

3. (b) If veteran, name war _____

6. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 85 Months 8 Days 27
If less than one day _____ hr. _____ min.

9. Birthplace St. Genevieve County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct 3 - 41 (b) T. J. Robinson
(Date received local registrar) (Registrar's signature)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 29
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. Appleberry (M. D. or other) _____

Address Farmington Mo Date signed _____

SUPPLEMENTAL COPY