

FILED JAN 8 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43834

State File No. _____

Registration District No. 700

Primary Registration District No. 700

Registrar's No. 2410

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Rose Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks 4 days
(Specify whether
In this community 63 yrs. 7 mos. 10 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1929 Benton St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME CLIFFORD THOMAS E

3. (b) If veteran, name war no 8. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased May 9, 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 7 10 _____ hr. _____ min.

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

10. Usual occupation Constable

11. Industry or business _____

12. Name Joseph Clifford

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

14. Maiden name Margaret Cody

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

16. (a) Informant John Clifford

(b) Address 1929 Benton St.

17. (a) Burial (b) Date thereof Dec. 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Boochee Boochee

(b) Address 2228 St. Louis Ave

19. (a) DEC 21 1940 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 19
year 40 hour 2 minute 20 P. M.

21. I hereby certify that I attended the deceased from 12/11, 1940 to 12/19, 1940

that I last saw him alive on 12/19/40
and that death occurred on the date and hour stated above.

Immediate cause of death Far advanced Pulmonary Tuberculosis
Duration 1 1/2 yrs.

Due to _____

Due to 73

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

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? 940 (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 J. E. Gerson (M. D. or other) _____

Address St. Rose Sanatorium Date signed 12-19-40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

May 9 - 6 1971

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 Charles Goodhart
Licensed Embalmer No. 2777

P. O. Address _____

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.