

Registration District No. FILED JUL 7 1941 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: O.K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution eight days  
(Specify whether years, months or days) 45 yrs.

3. (a) PRINT FULL NAME MICHAEL CLIFFORD

3. (b) If veteran, name war. No 3. (c) Social Security No. 443-17-6918

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

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

7. Birth date of deceased. July 3 1867  
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 11 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation. Shipping clerk

11. Industry or business. Falls City Foods Co.

12. Name Francis Clifford

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

14. Maiden name Stanora Foley

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

16. (a) Informant Catherine Clifford  
(b) Address 509 E 27th K.C. Mo.

17. (a) Burial (b) Date thereof 6-15-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT St. Marys

18. (a) Signature of funeral director. J. F. O'Donnell Co.  
(b) Address 3256 Broadway, K.C. Mo.  
19. (a) 6/16/41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 509 East 27th St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th  
year 1941 hour 9 minute 55 P. M.

21. I hereby certify that I attended the deceased from June 6th 1941 to June 14th 1941, and that death occurred on the date and hour stated above.

that I last saw him alive on June 14th, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death. Bilateral lower lobe pneumonia and Atrophic cirrhosis of liver  
Due to \_\_\_\_\_  
Due to 108  
Other conditions (include pregnancy within 3 months of death) 108

Major findings: Of operations \_\_\_\_\_  
Of autopsy See above

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) (2) Means of injury \_\_\_\_\_  
23. Signature Dr. R. F. Thoin (M. D. or other) O  
Address Med. Dir. K.C. Gen. Hospital Date signed 6-16-41

Duration  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

---

---

**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:.....

*Park H. Rowe*

Licensed Embalmer No. ....

*2347*

P. O. Address.....

*X. C. W.*

**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, fact should be so stated above.**