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4-41  
17-39  
X28390

DEC 13 1941

Registration District No. **799**

Primary Registration District No. **4479**

1. PLACE OF DEATH:

(a) County **Saline**

(b) City or town **Slater *Jun***  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **none**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **50 yrs** (Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Saline** **097**

(c) City or town **Slater** **1**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **Lark Clifford**

3. (b) If veteran, name war **no**

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **15th**  
year **1941** hour **9** minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from **Oct. 21 -** 1941 to **Nov. 15 -** 1941  
that I last saw him alive on **Nov. 15 -** 1941  
and that death occurred on the date and hour stated above.

4. Sex **male** **0**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **3 divorced**

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased **Jan. 16 1874**  
(Month) (Day) (Year)

Immediate cause of death **Coronary occlusion**

Due to \_\_\_\_\_

Duration \_\_\_\_\_

8. AGE: Years **67** Months **9** Days **29**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to **Cholelithiasis**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace **New Franklin Mo. 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **laborer**

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN **126**

Underline the cause to which death should be charged statistically.

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

12. Name **Wm. Clifford**

13. Birthplace **Canada** **2**

14. Maiden name **Theresa Pickard** (State or foreign country)

15. Birthplace **Canada** **2**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. W. C. Clifford**

(b) Address **Slater, Mo.**

17. (a) **burial** (Burial, cremation, or removal) (b) Date thereof **11-17-'41**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Slater, Mo.**

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? \_\_\_\_\_

18. (a) Signature of funeral director **Hill Brothers**

(b) Address **Slater, Mo.**

19. (a) **12-2-1941** (Date received local registrar) (b) **Ella Alexander** (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature **E. W. Redwell** (M. D. or other)

Address **Slater, Mo.** Date signed **12-29**

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

MOTHER FATHER

708

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-11-41.....

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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 Edgar Moore.....  
Licensed Embalmer No. 4187.....  
P. O. Address State Mo......

**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.**