

FILED SEP 7 1944
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Lakeside Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 hrs
(Specify whether years, months or days)

In this community 3 hours

3. (a) PRINT FULL NAME INFANT CLIFTON

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased August 24, 1944
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			<u>3</u> hr. <u>S</u> min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name John E. Clifton

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

14. Maiden name Randa Mae Fletcher

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

16. (a) Informant Floy Bleas Baker

(b) Address 303 S. Indiana

17. (a) Burial (b) Date thereof August 26, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son,

(b) Address Kansas City, Mo.

19. (a) 8-26-44 (b) M. E. Brown
(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. 303 S. Indiana
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1944 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 24 1944 to Aug 24 1944
that I last saw her alive on Aug 24 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to 6 months pregnancy

Other conditions 159
(Include pregnancy within 3 months of death)

Duration

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? _____

23. Signature Dr. Carl T. Moore (M. D. or other) MD
Address 6508 E. 37th Date signed 8-25-44

361

Dr. Carl Moore
Linds, Mo.

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.