

FILED FEB 2 1945

Registration District No. **274**

Primary Registration District No. **3012**

Registrar's No. **15**

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

**1. PLACE OF DEATH:**  
 (a) County Pettis  
 (b) City or town Sedalia  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
408 N. Hurley  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 29 years years, months or days)

**3. (a) PRINT FULL NAME** Clarence Plez Wickliffe

**3. (b) If veteran, name war** \_\_\_\_\_ **3. (c) Social Security No.** \_\_\_\_\_

**4. Sex** Male **5. Color or race** White  
**6. (a) Single, widowed, married, divorced** Married  
**6. (b) Name of husband or wife** Bessie Wickliffe  
**6. (c) Age of husband or wife if alive** 48 years  
**7. Birth date of deceased** March 2 1891  
(Month) (Day) (Year)

8. AGE:				If less than one day
Years	Months	Days	hr. min.	
<u>53</u>	<u>10</u>	<u>8</u>		

**9. Birthplace** Benton County Missouri  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Machinist, Mo. Pacific Shops

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

**MOTHER FATHER** { **12. Name** Pleasant Wickliffe  
**13. Birthplace** Missouri  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Mary Stewart  
**15. Birthplace** Missouri  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Mrs. Opal Wade  
**(b) Address** 407 N. Hill

**17. (a) Burial** (Burial, cremation, or removal) **(b) Date thereof** Jan. 13, 1945  
(Month) (Day) (Year)

**(c) Place: burial or cremation** Crown Hill Cemetery

**18. (a) Signature of funeral director** McLaughlin Bros.  
**(b) Address** Sedalia, Missouri

**19. (a) 1-11-45** (Date received local registrar) **(b) Mrs. Anna Berger** (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Pettis  
 (c) City or town Sedalia  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 408 N. Hurley  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Jan day 10  
 year 1945 hour 11:20 minute PM

**21. I hereby certify that I attended the deceased from** 8-2-44 to Jan 10-1945  
 that I last saw him alive on Jan 5-1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion **Duration** Sudden

Due to Coronary Hypertrophy + nephritis

Due to General Anoxia

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

**Major findings:**  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

**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** Albert B. Thomas (M. D. or other)  
 Address 110 W. 4th Sedalia Mo. Date signed 1-11-45

1022

RECEIVED  
COUNTY OFFICE NO. 2  
Date Filed 2-1-45

FEB 8 1945

5

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 K.P.M. Laury  
Licensed Embalmer No. 3153  
P. O. Address Bedalia 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb  
Registrar's No. 15

Registration District No. 274 Primary Registration District No. 3052

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

1. PLACE OF DEATH:  
(a) County Pettis  
(b) City or town Sedalia  
(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)

3. (a) PRINT FULL NAME Clarence P. Wickliff  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 2 (Month) (Day) (Year)

8. AGE: Years 53 Months 10 Days \_\_\_\_\_ (Unless than one day) min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

MOTHER FATHER  
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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan Day 10 Year 1945 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to Chronic Myeloid  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED  
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 Dr. Fred W. Turner (M. D. or other) \_\_\_\_\_  
Address 111 W. of Sedalia Mo. Date signed 2-10-45

SUPPLEMENTARY

3062