

V. S. No. 2
FORM-8-43
Rev. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17261

FILED JUN 11 1945

State File No. 17261

Registration District No. 164

Primary Registration District No. 3022

Registrar's No. 42

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

1. PLACE OF DEATH:

(a) County Johnson

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

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

(d) Length of stay: In hospital or institution. no
(Specify whether years, months or days) 64 Yrs 3 Mo.

3. (a) PRINT FULL NAME Daniel Patrick Clifford

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

3. (c) Social Security No. _____

4. Sex Male 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. Feb 11 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>3</u>	<u>0</u>	hr. _____ min.

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

10. Usual occupation. Butcher

11. Industry or business. Slaughter House

12. Name John Clifford

13. Birthplace. _____ Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Mary Shay

15. Birthplace. Maretta Ohio 1
(City, town, or county) (State or foreign country)

16. (a) Informant Kathrin Clifford

(b) Address Warrensburg Mo

17. (a) Burial (b) Date thereof. 5-14-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Sunset Hill

18. (a) Signature of funeral director. Sweeney Phillips

(b) Address Warrensburg Mo.

19. (a) May 12 1945 (b) Reola M. Williams
(Date recorded local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson 51

(c) City or town Warrensburg
(If outside city or town limits, write "RURAL")

(d) Street No. 312 Marshal
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11
year 1945 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 11, 1945, to May 11, 1945.
that I last saw him alive on 9 am May 11, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death. Heart block, aortic
Sclerosed arteries

Due to Alcoholism

Due to Drugs - all his life

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations no operations

Of autopsy no autopsy

Duration _____
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) no

(b) Date of occurrence _____

(c) Where did injury occur? no injury (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? no (Specify type of place) (e) Means of injury. 0

23. Signature John T. Anderson (M. D. or other)

Address Warrensburg Date signed May 11 1945

1001

(Licensed Embalmer's Statement on Reverse Side)

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.....

J. Earl Parent

Licensed Embalmer No. **3878**

P. O. Address **Warrensburg 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.