

FILED SEP 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30729

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3028 Registrar's No. 107

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carthage		c. LENGTH OF STAY (In this place) 6 mos.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Sheets Convalescent Home		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carthage	
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) ANN c. (Last) CLIFTON		4. DATE OF DEATH (Month) (Day) (Year) Sept 9, 1949	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH October 29, 1866
9. AGE (In years last birthday) 82		10. MONTH 10	11. DAY 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (State or foreign country) Poweshiek County, Iowa
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Martin Koester	
13b. MOTHER'S MAIDEN NAME Elizabeth Comstock		14. NAME OF HUSBAND OR WIFE Geo. Wash. Clifton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Homer A. Sears, Traer, Iowa	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tok over Myocarditis ANTECEDENT CAUSES As stated Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 4222	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 10, 1949 to Sept 9, 1949 , that I last saw the deceased alive on _____, 19____, and that death occurred at 4:30p m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) H. B. Baker M.D.		23b. ADDRESS Carthage, Mo.	23c. DATE SIGNED 9-10-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept 13, 1949	24c. NAME OF CEMETERY OR CREMATORY Park Cemetery	24d. LOCATION (City, town, or county) (State) Carthage, Mo.
DATE REC'D BY LOCAL REG. 9-10-49	REGISTRAR'S SIGNATURE L. B. Clifton	25. FUNERAL DIRECTOR'S SIGNATURE Knell Mortuary, Carthage, Mo.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

49

46
1
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Per. H. Ferguson (Licensed Embalmer's Statement on Reverse Side)

RECEIVED 9-20-49
Jasper County Health Office

County File Number 49-9-702
Date Filed 9-24-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Robert H. Knell

Signed _____
Student Embalmer

Licensed Embalmer No. 4459

P. O. Address Carthage

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.