No. 300
10.48

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

FILED JAN 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41415

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 197

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Prairie Twp
c. LENGTH OF STAY (in this place): 2 Mth 10 D
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jackson Co. Home, S

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): _____

3. NAME OF DECEASED (Type or Print)
a. (First): ANNIE
b. (Middle): —
c. (Last): CLIFFORD

4. DATE OF DEATH (Month) (Day) (Year): 12-15-49

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: 1-12-1873
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Sedalia, Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no —
17. INFORMANT'S SIGNATURE OR NAME: Jackson Co. Home, Rt. #4 — ADDRESS: Indep. Mo

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): Chronic myocarditis

ANTECEDENT CAUSES

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.

INTERVAL BETWEEN ONSET AND DEATH: 4 2 2 2

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/5, 1949 *to* 12/15, 1949, *that I last saw the deceased alive on* 12-15, 1949 *and that death occurred at* 12:05 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: J W Greene M.D. (Degree or title)
23b. ADDRESS: Independence Mo
23c. DATE SIGNED: 12/16/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/16/49
24c. NAME OF CEMETERY OR CREMATORY: Lee's Summit
24d. LOCATION (City, town, or county) (State): Lee's Summit Mo

DATE REC'D BY LOCAL REG.: 12-15-49
REGISTRAR'S SIGNATURE: Donald C. Eamshaw 318
25. FUNERAL DIRECTOR'S SIGNATURE: N Blangford — ADDRESS: Lee's Summit Mo

(Licensed Embalmer's Statement on Reverse Side)

DEC 2 9 1949

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.

Not Embalmed

Signed ..... Student Embalmer

Signed N B Laney Ford

Licensed Embalmer No. 3833

P. O. Address Leis Summit

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.