

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10285

#21411

State File No.

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 2406

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2406	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give town) St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 1617 Missouri Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) EMMETT		b. (Middle) _____		c. (Last) CLIFTON		4. DATE OF DEATH (Month) (Day) (Year) March 12th, 1950	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH June 8, 1872	
9. AGE (In years last birthday) 77		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) Perry Co., Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Robert Clifton		13b. MOTHER'S MAIDEN NAME Caroline Cashion		14. NAME OF HUSBAND OR WIFE Cora	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Katie Clifton 2845 S. 19th St.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of bile duct ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) biliary obstruction DUE TO (c) _____					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) 153X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 11/28/49 to 3/12/50, 19____, that I last saw the deceased alive on 3/12/50, 19____, and that death occurred at 2:50am, from the causes and on the date stated above.							
23a. SIGNATURE C. Allen McAfee M.D. (Degree or title)				23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 3/13/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-12-50		24c. NAME OF CEMETERY OR CREMATORY Crossstown		24d. LOCATION (City, town, or county) (State) Mo	
DATE REC'D BY LOCAL REG. WAR 13 1950		REGISTRAR'S SIGNATURE J.P. Luster		25. FUNERAL DIRECTOR'S SIGNATURE 4104 ADDRESS Rowland Mortuary S.W. 28th St.			

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

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.

Student
Student Embalmer

Signed *J. Allen Davis Jr*.....

Licensed Embalmer No. *40563*.....

P. O. Address *404 Manchester*.....

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.