

FILED OCT 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30003**

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BIRTH NO. _____		REG. DIST. NO. 128	PRIMARY REG. DIST. NO. 2000	Registrar's No. 849
1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Greene		
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN Springfield	c. LENGTH OF STAY (in this place) 20 YRS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		
d. FULL NAME OF HOSPITAL OR INSTITUTION 340-N. Clay		d. STREET ADDRESS (If rural, give location) 340-N. Clay		
3. NAME OF DECEASED (Type or Print) a. (First) CLIFFORD b. (Middle) A c. (Last) HEWITT		4. DATE OF DEATH (Month) (Day) (Year) 9-26-50		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb-5-1886	9. AGE (In years last birthday) 64
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Fayetteville Ark	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. John Hickman 340-N. Clay	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probably Coronary thrombosis		ANTECEDENT CAUSES		4201
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		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"/>	
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)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:30 a. m. , from the causes and on the date stated above.				
23a. SIGNATURE W.E. Handley MD		23b. ADDRESS City Hall Springfield MO		23c. DATE SIGNED 9/26-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-29-50		24c. CEMETERY OR CREMATORY Lincoln Memorial
24d. LOCATION (City, town, or county) (State) Springfield MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.V. Smith-602-N. Jefferson		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 9-26-50 W.E. Handley MD				

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

UNATTENDED BY A PHYSICIAN

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 Herbert J. Smith

Licensed Embalmer No. 4284

P. O. Address Springfield

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.