No. 300
10-48

FILED DEC 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39216

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 2861

1. PLACE OF DEATH
a. COUNTY St Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clayton
c. LENGTH OF STAY (in this place) 11 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 11 S. Jackson Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY St Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 45 Clayton 4452
d. STREET ADDRESS (If rural, give location) 11 S. Jackson Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Cora b. (Middle) M. c. (Last) Clifford

4. DATE OF DEATH (Month) (Day) (Year) Nov. 25 1950

5. SEX F1
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Aug. 21 - 1879
9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months 3 Days 4 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) St Louis
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Patrick J Clifford
13b. MOTHER'S MAIDEN NAME Catherine Hamm
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME 6668 ADDRESS Florence E Trotman Delmar

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) cause unknown — INTERVAL BETWEEN ONSET AND DEATH unk

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. 7955

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 7955
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 _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Herbert R Domke (Degree or title) Local Registrar - Vital Statistics
23b. ADDRESS 651 Brentwood Blvd. Clayton, Mo.
23c. DATE SIGNED 11-27-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Buried
24b. DATE Nov 29
24c. NAME OF CEMETERY OR CREMATORY Bellefontaine
24d. LOCATION (City, town, or county) St Louis (State) Mo

DATE REC'D BY LOCAL REG. 11/27/50
REGISTRAR'S SIGNATURE Herbert R Domke MD
25. FUNERAL DIRECTOR'S SIGNATURE Louis H. Bapp Inc ADDRESS Kirkwood Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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 Felix Durand

Licensed Embalmer No. 3034

P. O. Address Kirkwood 22

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.