

FILED APR 9 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2583
Registrar's No. 353

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Clinton	
b. CITY OR TOWN St. Joseph	c. LENGTH OF STAY (in this place) 1 day	c. CITY OR TOWN Lathrop 0250	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		d. STREET ADDRESS (If rural, give location) none . /	

3. NAME OF DECEASED
(Type or Print) a. (First) **CLARENCE** b. (Middle) **M** c. (Last) **KIEFFER**

4. DATE OF DEATH **March 30, 1951**

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 13, 1901	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 60 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13a. FATHER'S NAME **William Kieffer** 13b. MOTHER'S MAIDEN NAME **Rose L Newton** 14. NAME OF HUSBAND OR WIFE **Irene Kieffer**

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. **none**

17. INFORMANT'S SIGNATURE OR NAME **Irene Kieffer Lathrop, Mo.** ADDRESS _____

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Myelogenous leukemia**

INTERVAL BETWEEN ONSET AND DEATH **13 mo**

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.

19a. DATE OF OPERATION **none** 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)
2041

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 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 **3-21, 1951** to **3-30, 1951**, that I last saw the deceased alive on **3-30, 1951**, and that death occurred at **2:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Ed Grant M.D.** 23b. ADDRESS **St. Joseph Mo** 23c. DATE SIGNED **3.31.51**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **April 3, 1951** 24c. NAME OF CEMETERY OR CREMATORY **Mt. Olivet Cem.** 24d. LOCATION (City, town, or county) (State) **St. Joseph, Mo.**

DATE REC'D BY LOCAL REG. **April 9, 1951** REGISTRAR'S SIGNATURE **Carl C. Post** 446 25. FUNERAL DIRECTOR'S SIGNATURE **Earl H. Clark** ADDRESS **120 Illinois Ave**

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

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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed

Will J. Chaney

Signed.....

Student Embalmer

Licensed Embalmer No. *4679*

P. O. Address

St. Joseph, Mo.

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.