

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20389  
2913

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

FILED JUL 5 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1001

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Lutheran</u>		d. STREET ADDRESS (If rural, give location) <u>3/95 E. 35th St.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Esther</u> b. (Middle) <u>Ann</u> c. (Last) <u>Clift</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6 26 52</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Wid</u>	8. DATE OF BIRTH <u>10/20/1893</u>
9. AGE (In years last birthday) <u>58</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) <u>Malta Bend, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>Robert E. Carter</u>		13b. MOTHER'S MAIDEN NAME <u>Lina Pauline Waller</u>	
14. NAME OF HUSBAND OR WIFE <u>Harry A. Clift</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Carter Schieszer</u> ADDRESS <u>3495 E. 35th</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer Lung ??</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>  ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  <u>103X</u>	
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 <u>1 April, 1952 to 26 June, 1952</u> that I last saw the deceased <input checked="" type="checkbox"/> alive on <u>26 June, 1952</u> and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Robert M. Myers</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>1025 Malta Bldg</u>	23c. DATE SIGNED <u>27 June</u>
24a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/20/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Malta Bend Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Malta Bend, Mo. 5</u>
DATE REC'D BY LOCAL REG. <u>6-27-52</u>	REGISTRAR'S SIGNATURE <u>Seraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. P. Sheil</u> ADDRESS <u>K.C. Mo</u>	

(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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed

*R. E. Canall*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4828*

P. O. Address *F. E. No.*

**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.