

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

 State File No. **42218**
5304

 FILED DEC 20 1952
 BIRTH NO.

 REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) township) Unk.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		3288
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2			d. STREET ADDRESS (If rural, give location) Robt. E. Lee Hotel		
3. NAME OF DECEASED (Type or Print) a. (First) Airman 1st Cl. Joel C. Clyburn b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 12/4/52		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 12/14/32	9. AGE (In years last birthday) 19	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Elizabeth, New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Odesa		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes		16. SOCIAL SECURITY NO. 1-17-32	17. INFORMANT'S SIGNATURE OR NAME ADDRESS U. S. Air Force K. C. Mo.		
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.					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Shock & Hemorrhage					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Bullet wound					
DUE TO Shock					
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 Autopsy by Gen Stamps			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT (Specify) Homicide		21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12th St	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) K.C. Jackson Mo		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12/3/52 10:45 AM		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Bullet wound		
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 John G. Conner			23b. ADDRESS 1612 E 12th		23c. DATE SIGNED 12/5/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/5/52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) New York City, N. Y.	
DATE REC'D BY LOCAL REG. 12-5-52		REGISTRAR'S SIGNATURE Seraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Reed, 18th & Leaton	

 WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
 THOS. A. JONES, M.D.

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

Bruce L. Watkins

Licensed Embalmer No. 4500

P. O. Address 18th & Benton

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.