V.S. No. 300
Rev. 10.48

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

State File No. 31740

FILED OCT 6 1953

BIRTH NO. ____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4449

6

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

**1. PLACE OF DEATH**
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 50 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Mary's Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 4155 Holly 3708 0

**3. NAME OF DECEASED** (Type or Print)
a. (First): Mrs
b. (Middle): Margaret
c. (Last): Clifford

**4. DATE OF DEATH** (Month) (Day) (Year): Sept 9 53

**5. SEX**: Fe 1
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Widow 2
**8. DATE OF BIRTH**: Aug. 29, 1884
**9. AGE** (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: ——
**11. BIRTHPLACE** (City and State or Foreign Country): County Galway, Ireland 4
**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13a. FATHER'S NAME**: Thomas Audley
**13b. MOTHER'S MAIDEN NAME**: unknown
**14. NAME OF HUSBAND OR WIFE**: Jerry Clifford (De)

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes, give war or dates of service)
**16. SOCIAL SECURITY NO.**: ——
**17. INFORMANT'S SIGNATURE OR NAME**: John J. Clifford
**ADDRESS**: 4155 Holly

**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) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Essential hypertension — 2 yrs.

DUE TO (c) and arteriosclerotic heart disease — 4 yrs.

II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not related to the disease or condition causing death.*

Nil.

**19a. DATE OF OPERATION**
**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)
**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* 1-12, 1949, *to* 9-9-53, 19____, *that I last saw the deceased alive on* 9-9-53, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

**23a. SIGNATURE** Graham Owens (Degree or title) Graham Owens M.D.
**23b. ADDRESS**: 906 Grand K C Mo.
**23c. DATE SIGNED**: 9-10-53

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: Sept. 12, 53
**24c. NAME OF CEMETERY OR CREMATORY**: St Mary's Cemetery
**24d. LOCATION** (City, town, or county) (State): Kansas City, Mo

**DATE REC'D BY LOCAL REG.**: 9-11-53
**REGISTRAR'S SIGNATURE**: Geraldine Smith
**25. FUNERAL DIRECTOR'S SIGNATURE**: Quirk & Robin
**ADDRESS**: 20 West Linwood

(Licensed Embalmer's Statement on Reverse Side)

## 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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.