

IC-1724 537

Reg. #19847

SL #11625

FILED NOV 29 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39300

STATE FILE NUMBER

10399

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Iron	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		c. CITY OR TOWN VULCAN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS (If outside, give location) 29 days	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C. Last CLIFFORD		4. DATE OF DEATH Month NOVEMBER Day 14 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/94
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		9b. AGE (In years last birthday) 62	
10a. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) VULCAN, MISSOURI	
13. FATHER'S NAME JIM CLIFFORD		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT VA HOSP. RECORDS, ST. LOUIS, MO.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONFLUENT RIGHT LOWER LOBE PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 1 week
DUE TO (b) CHRONIC LYMPHATIC LYMPHOMA			2 years
DUE TO (c) 2021			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. Attended the deceased from 10/16/56 to 11/14/56 and last saw him alive on 11/14/56		Death occurred at 6:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE W. Kaminski (Degree or title) M.D.		22b. ADDRESS 915 N. Grand VAH, ST. LOUIS, MO.	22c. DATE SIGNED 11/14/56
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE 11/15/56	23c. NAME OF CEMETERY OR CREMATORY Piedmont, Mo	23d. LOCATION (City, town, or county) (State) Piedmont Mo
24. FUNERAL DIRECTOR Edward Fendler ADDRESS 5611 South Grand Blvd.	25. DATE RECD. BY LOCAL REG. NOV 14 1956	26. REGISTRAR'S SIGNATURE Carl Smith MD	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes. diseases in Part I must be causally related.

1001

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Harry J. Schmitt*

Licensed Embalmer No. *X*

P. O. Address *5611*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**.
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.