

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2372  
STATE FILE NUMBER

FILED JAN 22 1958

Registration District No. 290 Primary Registration District No. 5985 Registrar's No. 8

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>Yakima</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fort Leonard Wood</u>		c. CITY OR TOWN <u>Grand View</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>US Army Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u>	
Length of stay in lb <u>-</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>CLIFFORD</u> Middle <u>MARION</u> Last <u>CAMERON</u>			4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 April 1914</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>	11. BIRTHPLACE (City and state or country) <u>Yakima, Washington</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Deceased</u>	13b. MOTHER'S MAIDEN NAME <u>Suzan E Bigliere</u>	14. NAME OF HUSBAND OR WIFE <u>- -</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes (30 Oct 42 to present)</u>	16. SOCIAL SECURITY NO. <u>538-09-5277</u>	17. INFORMANT <u>ORVIS J TRUDE Capt MSC Ft Leonard Wood, Mo</u>	Address <u>US Army Hospital</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous hemorrhage, thalamus and pons</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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.)
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20c. TIME OF INJURY Hour _____ 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 _____
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21. I <u>saw</u> the deceased <u>on</u> <u>13 Jan 1958</u> at <u>4:15</u> P on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>James B. White, Capt, MC</u>	22b. ADDRESS <u>US Army Hospital Fort Leonard Wood, Missouri</u>	22c. DATE SIGNED <u>14 Jan 58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	23d. LOCATION (City, town, or county) (State) <u>Wanato, Washington</u>
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24. FUNERAL DIRECTOR <u>Hedges Funeral Homes Inc</u>	25. DATE RECD. BY LOCAL REG. <u>MO 1-14-58</u>	REGISTRAR'S SIGNATURE <u>Paula Grace Anderson</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms were observed. All diseases in Part I must be causally related.

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 *Clarence Cross* .....

Licensed Embalmer No. *4896* .....  
P. O. Address *Raynsville, Me* .....

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.