

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022151

STATE FILE NUMBER

273

FILED JUL 3 1958

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 273

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, give TOWNSHIP only) TOWN Independence			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Blue Springs Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hosp & Sanitarium			Length of stay in lb 1 day		d. STREET ADDRESS (If outside, give location) West Vesper St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gayle Middle Park Last Clemmons				4. DATE OF DEATH Month June Day 21 Year 1958			
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 Oct. 11 1912		9. AGE (In years last birthday) 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY Tool & Dye		11. BIRTHPLACE (City and state or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Walter M. Clemmons				14. MOTHER'S MAIDEN NAME Cora Mabel Reavis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Goldie Clemmons		Address Blue Spring Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion							INTERVAL BETWEEN ONSET AND DEATH 30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)		DUE TO (c)		4201
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 type="checkbox"/> NO <input checked="" 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 4:45 Month, Day, Year 6-21-58 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 Blue Springs, Mo		COUNTY STATE	
21. I attended the deceased from 6-19-58 to 6-21-58 and last saw her/him alive on 6-20-58 Death occurred at 4:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Merrill R. Ray M.D.				22b. ADDRESS Blue Springs, Mo		22c. DATE SIGNED 6-21-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 24/58	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cem.		23d. LOCATION (City, town, or county) (State) Raytown Mo.			
24. FUNERAL DIRECTOR Webb Funeral Home, Blue Springs Mo			ADDRESS		25. DATE RECD. BY LOCAL REG. 6-24-58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service
300 0
1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
354 0

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

8961 6 TNR.

JUL 2 1958

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 *William Freil*

Licensed Embalmer No. *47*

P. O. Address *Blue Springs*

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.