

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036316

STATE FILE NUMBER

FILED OCT 23 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4634

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RESEARCH HOSPITAL</b>		Length of stay in (b) <b>37 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>4241 HARRISON ST</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA Jane CLIFTON</b>			4. DATE OF DEATH Month Day Year <b>SEPTEMBER 30 1958</b>		
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 12, 1880</b>	9. AGE (In years last birthday) <b>78</b>	10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	11. BIRTHPLACE (City and state or country) <b>JANE, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>JAKE SEARS</b>	13b. MOTHER'S MAIDEN NAME <b>CAROLINE BOLT</b>	14. NAME OF HUSBAND OR WIFE <b>THOMAS C. CLIFTON</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>508-14 0281</b>	17. INFORMANT <b>THOMAS C. CLIFTON, 4241 HARRISON</b>	Address
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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) <b>Acute Myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary artery thrombosis</b>	<b>4-20</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) <b>Bronchial asthma; Hypertension; Bronchopneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 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
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21. I attended the deceased from <b>12-28-49</b> to <b>9-30-58</b> and last saw <sup>her</sup> alive on <b>9-30-58</b> Death occurred at <b>1:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Martin J. Mueller M.D.</b>	(Degree or title) <b>D</b>	22b. ADDRESS <b>555 Angelle Bldg K C Mo.</b>	22c. DATE SIGNED <b>10-2-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT-2-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FLORAL HILLS CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEUXOMER'S SONS</b>	ADDRESS <b>133 BRUSH CREEK KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>10-2-58</b>	26. REGISTRAR'S SIGNATURE <b>Irlva Marshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

Martin J. Mueller USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

No symptoms will be listed.



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 Chester K Brown

Licensed Embalmer No. 493  
P. O. Address KE Md

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.