

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021272

FILED JUN 17 1959

Registration District No. 149

Primary Registration District No. 1002

STATE FILE NO. 2568

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE MISSOURI b. COUNTY CLINTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN HOLT	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		d. STREET ADDRESS (If outside, give location) 0250 NONE	
3. NAME OF DECEASED (Type or print) First ROBERT Middle HOOVER Last CLOWER		4. DATE OF DEATH Month MAY , Day 23 , Year 1959	
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 JANUARY 2, 1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent-Oil Co. Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) FLOYD, VIRGINIA
13a. FATHER'S NAME E. T. CLOWER		13b. MOTHER'S MAIDEN NAME LUCY KING	14. NAME OF HUSBAND OR WIFE HELEN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 500-14-5237	17. INFORMANT Address Official Records VA Hospital, K.C., 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) Asphyxia due to aspiration vomitus			INTERVAL BETWEEN ONSET AND DEATH 9217
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 46			
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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 123 COUNTY _____ STATE _____	
21. I attended the deceased from May 19, 1959 to May 23, 1959 and last seen alive on May 23, 1959 Death occurred at 4:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert Hoover Clower (Degree of wife) ROBERT HOOVER CLOWER, M.D.		22b. ADDRESS VA Hospital, K.C., Mo.	
		22c. DATE SIGNED 5-23-59	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
Removal 5-23-59		5-23-59	
23c. NAME OF CEMETERY OR CREMATORY Sathrop, Mo.		23d. LOCATION (City, town, or county) (State) Sathrop, Mo.	
24. FUNERAL DIRECTOR Ed Mass		25. DATE RECD. BY LOCAL REG. 5-23-59	
ADDRESS Sathrop, Mo.		26. REGISTRAR'S SIGNATURE Neva Minchall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service

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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. 11272

: P. O. Address Falham,

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.