

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-036963

FILED IN SEP 21 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2638

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Length of stay in 1b <u>1 Day</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5079 Waterman</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>P.</u> Last <u>Clifford</u>			4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1900</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate Co.</u>		11. BIRTHPLACE (City and state or country) <u>Venice, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Charles Joseph Phayer</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Bushell</u>		14. NAME OF HUSBAND OR WIFE <u>Ina Clifford</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give type or dates of service) <u>Yes World War # I</u>		16. SOCIAL SECURITY NO. <u>197-03-3397</u>		17. INFORMANT <u>Medical Record</u> 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) <u>Cardiac arrest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sec.</u> <u>Min.</u> <u>Yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute Coronary occlusion</u>	
	DUE TO (c) <u>Coronary Sclerosis</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Usual Pneumonia right base & Pleurisy</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 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. I attended the deceased from <u>9/4/60</u> to <u>9/5/60</u> and last saw him alive on <u>9/4/60</u> Death occurred at <u>2:10</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>William D McCann MD</u>		22b. ADDRESS <u>7011 Concordia Chapter 5</u>		22c. DATE SIGNED <u>9/5/60</u>
23a. BURIAL, CREMATION, REMOVAL, SPECIFIC	23b. DATE <u>9/8/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Edwardsville, Ill.</u>	
24. FUNERAL DIRECTOR <u>John J. Donnelly</u> ADDRESS <u>3840 Lindell Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>9-7-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Francis Miller

Licensed Embalmer No. 356

P. O. Address 38400

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.