# URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 27 1960

-60-038310
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5041

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|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo b. COUNTY Jackson |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b: 15 yrs. | c. CITY OR TOWN Kansas City — Inside Limits: Yes ☒ No ☐ |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran — Inside Limits: Yes ☒ No ☐ | d. STREET ADDRESS (If outside, give location) 2718 Troost — Reside on Farm: Yes ☐ No ☒ |

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|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or print) | First: HOWARD | Middle: W. | Last: CLIFFORD | 4. DATE OF DEATH | Month: Oct. | Day: 5 | Year: 1960 |
| 5. SEX: Male | 6. COLOR OR RACE: White | 7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒ | 8. DATE OF BIRTH: 5-29-1903 | 9. AGE (last birthday): 57 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HR: Hours / Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telegraph Operator | 10b. KIND OF BUSINESS OR INDUSTRY: K.C. Terminal | 11. BIRTHPLACE (City and state or country): Illinois | 12. CITIZEN OF WHAT COUNTRY: USA | | | | |
| 13a. FATHER'S NAME: Chas. M. Clifford | 13b. MOTHER'S MAIDEN NAME: Mary A. Parker | 14. NAME OF HUSBAND OR WIFE: Divorced | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None | 16. SOCIAL SECURITY NO.: 710-12-9106 | 17. INFORMANT: Mary A. Halehouser | Address: 2027 Cleveland KC Mo | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Hepatic Failure | 10 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) | Hemorrhage from Esophagus ~~Vaneis~~ VARICES | 12 days |
| DUE TO (c) | ~~Luners~~ Cirrhosis LANNEC'S | 5 yrs. |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 9-24-60
Pontival short wedge restorative of gastric ulcer

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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|---|---|---|---|---|
| 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ | 20a. ACCIDENT ☐ | SUICIDE ☐ | HOMICIDE ☐ | 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 ☐ NOT WHILE AT WORK ☐ | 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 October 30 1959, to _____ and last saw him alive on October 4, 1960

Death occurred at 4:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|---|---|
| 22a. SIGNATURE: W. H. Goodson MD (Degree or title) | 22b. ADDRESS: 730 Professional Bldg. | 22c. DATE SIGNED: 10/6/60 |

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|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10/7/60 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah | 23d. LOCATION (City, town, or county) (State): Kansas City, Missouri. |
| 24. FUNERAL DIRECTOR: Stine & McClure Funeral Home, ~~Kansas City, Mo.~~ | ADDRESS | 25. DATE RECD. BY LOCAL REG.: 10-7-60 | 26. REGISTRAR'S SIGNATURE: H. L. Dwyer |

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Wm. H. Goodson, Jr. MEDICAL CERTIFICATION DOCUMENT

**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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.