RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-043727

STATE FILE NUMBER

FILED VS NOV 28 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11092

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis
Length of stay in 1b: 2 weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St Luke's
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Jefferson
c. CITY OR TOWN: House Springs Mo
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): RT 2
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Charlette Middle: Lee Last: Cliff
4. DATE OF DEATH: Month: Nov. Day: 15 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10-18-53
9. AGE (last birthday): 7 yrs.
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): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): St Louis Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Marvin Cliff
13b. MOTHER'S MAIDEN NAME: Rosalie Johnson
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Marvin Cliff Address: House Springs Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL ANOXIA — INTERVAL BETWEEN ONSET AND DEATH: 8 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): CARDIAC ARREST (TREATED) — 8 HOURS
DUE TO (c): ANOXIA (COMPLETE ATELECTASIS LEFT LUNG — 8 1/2 HRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PATIENT UNDERGOING SURGERY FOR RT. LUNG DISEASE
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
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.)
759.0
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 11/5/60 to 11/15/60 and last saw her/him alive on 6 PM
Death occurred at 8:35 PM 11/15/60 on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Richard W. Moore M.D.
22b. ADDRESS: 52 Maryland Plaza
22c. DATE SIGNED: 11/16/60
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-19-60
23c. NAME OF CEMETERY OR CREMATORY: Asher Cemetery
23d. LOCATION (City, town, or county) (State): Reynolds Co. Mo.
24. FUNERAL DIRECTOR: Donald Sparks ADDRESS: Potosi Mo
25. DATE REC'D. BY LOCAL REG.: NOV 17 1960
26. REGISTRAR'S SIGNATURE: Earl Smith. M.D.

DOCUMENT

BY AFFIDAVIT OF

Cause of death - multiple cysts of both lungs

US NOV 28 1960

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 Donald Sparks

Signature of Student Embalmer

Licensed Embalmer No. 48 /

P. O. Address Potosi, M

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