

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045979

FILED VS DEC 19 1960 147

6061

STATE FILE NUMBER

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

INDEXED

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>			Length of stay in 1b <b>1 Year</b>		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>St. Luke's Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4852 Oak Street</b>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>L.</b> Last <b>CLYBURN</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>3,</b> Year <b>1960</b>			
5. SEX <b>Male</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>7/14/1890</b>	9. AGE (last birthday) <b>70</b>	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) <b>Clerk (Retired)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Rock Island Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Makanda, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Frank S. Clyburn</b>			13b. MOTHER'S MAIDEN NAME <b>Marguerite Harrison</b>			14. NAME OF HUSBAND OR WIFE <b>Edith M. Clyburn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) <b>No</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Mrs. Edith M. Clyburn, 4852 Oak, K.C., Mo.</b>		
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) <b>Coronary occlusion</b>							<b>13 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary arterio sclerosis</b>							<b>2 years</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>Carcinoma of Lung -</b>					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		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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		COUNTY	STATE
21. I attended the deceased from <b>1 January 1959</b> to <b>3 Dec 1960</b> and last saw him alive on <b>2 Dec 1960</b> Death occurred at <b>7:10 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Blaine Z. Hubbard M.D.</b>				22b. ADDRESS <b>411 Nichols RD KCMO</b>		22c. DATE SIGNED <b>3 Dec 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Dec. 3, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Tower Grove Cemetery</b>		23d. LOCATION (City, town, or County) (State) <b>Murphysboro, Illinois</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Freeman Mortuary, Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>12-3-60</b>	26. REGISTRAR'S SIGNATURE <b>H. L. Sawyer</b>		

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 J. S. Free

Licensed Embalmer No. 29

P. O. Address F. C.

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.