

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

106

61-020087

STATE FILE NUMBER

Registration District No. 336 Primary Registration District No. 336 Registrar's No. 336

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 31 1961

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>SHANNON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>IROQUOIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Winona, Missouri</u> | | c. CITY OR TOWN <u>Watsoka</u> | |
| Length of stay in 1b | | 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>4 miles south Hi way 19</u> | | d. STREET ADDRESS (If outside, give location) <u>300 E. Sheradan St.</u> | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHARINE GRACE CLIFTON</u> | | | 4. DATE OF DEATH Month Day Year <u>5 22 1961</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-22-93</u> |
| 9. AGE (last birthday) <u>67</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | 11. BIRTHPLACE (City and state or country) <u>WATSEKA</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>HARRY FISHER</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>William C. Clifton</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | |
| 17. INFORMANT <u>IVAN LOOKER - 130 E. Walnut, Watsoka</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>NATURAL CAUSES PROBABLE</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (b) <u>CORONARY THROMBOSIS</u> | | | |
| DUE TO (c) <u>CORONER of Shannon Co. Frank W. Jones</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Notified</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 |
| 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 a.m. p.m. Month, Day, Year | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Frank W. Jones Coroner Emeritus M.O.</u> | | 22b. ADDRESS | 22c. DATE SIGNED |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | 23b. DATE <u>5-25-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Crematory</u> | 23d. LOCATION (City, town, or county) (State) <u>Chicago, Ill.</u> |
| 24. FUNERAL DIRECTOR <u>Logan Funeral Home, Watsoka, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>May 29, 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Robert Jones</u> |

JUN 23 1961

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 Clement E. Clary

Licensed Embalmer No. 5118

P. O. Address Box 398, Winona, Mo

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.