

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-022927 ✓

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 10021 Registrar's No. 2769 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JUN 21 1962**

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>life</u>	c. CITY OR TOWN <u>Kansas City</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>St. Mary's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>711 Admiral Blvd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>E</u> Last <u>CLIFFORD</u>			4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1962</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>2-17-1903</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Station Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Municipal Air Terminal</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>John P. Clifford</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Malone</u>		14. NAME OF HUSBAND OR WIFE <u>Dorothy Clifford</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>[REDACTED]</u>		17. INFORMANT Address <u>Mrs. Dorothy Clifford 711 Admiral Blvd.</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>
IMMEDIATE CAUSE (a) <u>Uremia</u>		
DUE TO (b) <u>Chronic glomerulo-nephritis</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		
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 <u>X</u> 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 \_\_\_\_\_ to \_\_\_\_\_ and last saw <sup>her</sup>him alive on 5-21-62  
Death occurred at 7:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Harry S. Cohen M.D. (Doctor or title) 22b. ADDRESS 751 E 63rd St 22c. DATE SIGNED 5-22-62

23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial 23b. DATE 5-24-62 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 23d. LOCATION (City, town, or county) (State)  
Kansas City, Missouri

24. FUNERAL DIRECTOR Mellody-McGilley-Eylar ADDRESS Woodland 25. DATE RECD. BY LOCAL REG. 5-23-62 26. REGISTRAR'S SIGNATURE Ruth N Long

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

Harry S. Cohen  
MEDICAL CERTIFICATION

VS 300 Rev. 4/59

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Dr. Harry Cohen  
751 E. 63rd.  
Em 1-2123

1 PM 5 PM

**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 James E. Hackleman

Licensed Embalmer No. 4573

P. O. Address K. C. Inc.

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.

Signed