DEC 11 1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44545

Registration District No. 784 | Primary Registration District No. 101 | Registrar's No. 2171

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether)
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: ____

(c) City or town: Florrisant
(If outside city or town limits, write "RURAL")

(d) Street No.: Rt. #2 Lindburg Rd.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Michael Joseph Clifford

3. (b) If veteran, name war: ____ 3. (c) Social Security No.: ____

4. Sex: Male 5. Color or race: White 6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Cora V. Clifford 6. (c) Age of husband or wife if alive: 70 years

7. Birth date of deceased: Sept. 29th, 1868 (Month) (Day) (Year)

8. AGE: Years 71 | Months 2 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace: New Orleans (City, town, or county) Louisana (State or foreign country)

10. Usual occupation: Glass Worker

11. Industry or business: Retired

FATHER
12. Name: Patrick Clifford
13. Birthplace: ____ (City, town, or county) Louisana (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: ____ (City, town, or county) Unknown (State or foreign country)

16. (a) Informant's own signature: Mrs. Cora V. Clifford
(b) Address: Florrisant, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/11/39 (Month) (Day) (Year)
(c) Place: burial or cremation: Lake Charles Cemetery

18. (a) Signature of funeral director: Drehmann Harral
(b) Address: 1905 Union Blvd.

19. (a) DEC 11 1939 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9th year 1939 hour 12:40 minute A M.

21. I hereby certify that I attended the deceased from Oct 12, 1939 to Dec 8, 1939 that I last saw him alive on Dec 8, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Age	
Due to 94	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: ____
Of autopsy: Yes

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature: [illegible] (M. D. or other) ____
Address: Ferguson Mo. Date signed 12/9/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

25 a S. Florence Rd
1-3

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address.....

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 this body is not embalmed, above space should be left blank.