V. S. No. 2
00M—5-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

9738

State File No.

FILED APR 7 1944

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. 1387

1. PLACE OF DEATH:

(a) County JACKSON

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

(c) Name of hospital or institution: 5644 SWOPE PARKWAY
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---
(Specify whether In this community 35 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48 3

(c) City or town KANSAS CITY 8
(If outside city or town limits, write "RURAL")

(d) Street No. 5644 SWOPE PARKWAY
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country ---

3. (a) PRINT FULL NAME DR. WALTER MONROE CLEMMONS

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. MABEE CLEMMONS

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased MAY (Month) 13 (Day) 1878 (Year)

8. AGE: Years 65 | Months 10 | Days 15 | If less than one day ___ hr. ___ min.

9. Birthplace BATES COUNTY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation PHYSICIAN

11. Industry or business M. D.

FATHER
12. Name DEXTER P. CLEMMONS
13. Birthplace UNKNOWN (City, town, or county) ILLINOIS (State or foreign country)

MOTHER
14. Maiden name MARY FUGATE
15. Birthplace UNKNOWN (City, town, or county) VIRGINIA (State or foreign country)

16. (a) Informant Mrs Mabel Clemmons
(b) Address 5644 Swope Pkwy

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 30 1944 (Month) (Day) (Year)
(c) Place: burial or cremation FLORAL HILLS CEM.

18. (a) Signature of funeral director D. W. Newcomer's Sons
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 3-29-44 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

844

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 28TH year 1944 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from August 9, 1940, to Mar 28, 1944, that I last saw him alive on Mar 28, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion (repeated attacks)

Due to arteriosclerosis + osteo arthritis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

940

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 Annie Boutros (M. D. or other)

Address 416 Argyle Date signed 3-29-44

(Licensed Embalmer's Statement on Reverse Side)

416 Argyle Bldg
1-6

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 E. O. Hartley

Licensed Embalmer No. 1767

P. O. Address Kansas City 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 this body is not embalmed, fact should be so stated above.