

FILED JUN 13 1944
Registration District No.

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution: State Hospital No 2
(d) Length of stay: In hospital or institution 1 yr 9 mo 14 da
In this community yes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Independence
(d) Street No.
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Clifton B. See

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

4. Sex M. 5. Color or Grace H. 6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife Lucille See 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased July 24 1862

8. AGE: Years 81 Months 10 Days 0

9. Birthplace Mo O

10. Usual occupation Carpenter

11. Industry or business

12. Name William M. See

13. Birthplace Ky I

14. Maiden name Eliza Ann Adams

15. Birthplace Ky I

16. (a) Informant Geo. D. Hospital
(b) Address St Joseph Mo

17. (a) Burial (b) Date thereof 5-28-1944
(c) Place: burial or cremation Oak Hill Cem - Butler, Mo

18. (a) Signature of funeral director George C. Carson
(b) Address Independence, Missouri

19. (a) 5/28/44 (b) Delmar J. Peble

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
year 1944 hour 6-10 minute P. M.

21. I hereby certify that I attended the deceased from 5-20 1944 to 5-24 1944
that I last saw him alive on May 24 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Pneumonia

Due to
Due to

Other conditions: Arteriosclerosis with Psychosis

Major findings: Of operations
Of autopsy

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)
(e) Means of injury

23. Signature GEB alger (M. D. or other)
Address St Joseph Mo Date signed

Duration 24 hrs

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

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

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 *Floyd C. Carson*

Licensed Embalmer No. *4129*

P. O. Address *Independence*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. TempRegistration District No. 42Primary Registration District No. 1000Registrar's No. 589

1. PLACE OF DEATH:

- (a) County Buchanan
- (b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Clyton S. Lee

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ (Year)

7. Birth date of deceased July 27 1944
(Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 00 If less than one day _____ min. no

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
- (c) City or town _____
(If outside city or town limits, write "RURAL")
- (d) Street No. _____
(If rural, give location)
- (e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 10 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death Hypertensive Duration _____

- Due to _____

- Due to _____

- Other conditions arteriosclerosis with psychoses
(Include pregnancy within 3 months of death)

- Major findings: Of operations _____

- Of autopsy _____

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? _____

- While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

- Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTAL

17657