

FILED JUL 15 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

20372

Registration District No.

279

Primary Registration District No.

5957

Registrar's No.

18

1. PLACE OF DEATH

(a) County Pike
(b) City or town Eolia Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no (Specify whether
In this community 50 yrs (years, months or days)

3. (a) PRINT FULL NAME

Reinma Clifton

(b) If veteran, name war no

(c) Social Security No. no

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

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased July 31 1896
(Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 7 If less than one day — hr. — min.

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

10. Usual occupation School Teacher

11. Industry or business

12. Name Joseph Clifton

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

14. Maiden name Mary Clifton

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

16. (a) Informant Mrs. Jas. Graham

(b) Address Eolia, Mo.

17. (a) Burial (b) Date thereof June 8 9/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eolia Baptist Cemetery

18. (a) Signature of funeral director N.E. Esch

(b) Address Eolia Mo

19. (a) June 8 1948 (b) N.E. Esch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8
year 1948 hour 12 minute 30 AM.

21. I hereby certify that I attended the deceased from November 1944 to June 8 1948
that I last saw her alive on June 6 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis with myocardial degeneration
Due to Chronic nephritis
arterio-sclerotic kidneys

Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations —
Of autopsy 1310

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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? 0

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

23. Signature J. B. Hoeger (M. D. or other) M.D.
Address Whiteside, Mo. Date signed 6/8 1948

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

MOTHER FATHER

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 *Norman E. Gooch*

Licensed Embalmer No. *2342*

P. O. Address *Eolia, 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.

Registration District No. 279 Primary Registration District No. 5957

1. PLACE OF DEATH:

(a) County Pike Eolia
(b) City or town Eolia
(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 days3. (a) PRINT FULL NAME Owning Clifton

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased July 31
(Month) (Day) (Year)8. AGE: Years 51 Months 10 Day _____ If less than one Day _____ hr. _____ min.9. Birthplace Lingsdale Co., Mo
(City, town or county) (State or foreign country)10. Usual occupation Teacher in School

11. Industry or business

12. Name Joseph R Clifton13. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)14. Maiden name Mary Clifton15. Birthplace Pike Co Mo
(City, town or county) (State or foreign country)16. (a) Informant Mrs. James Graham(b) Address Eolia Mo17. (a) Burial (b) Date thereof June 10-1948
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Eolia Baptist Cemetery18. (a) Signature of funeral director Norman E. Sooch(b) Address Eolia Mo19. (a) June 9-1948 (b) N. E. Sooch Deputy
(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 _____
year 1948 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 _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

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?

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

SUICIDAL
TEMPORARY

S-20372