

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 18 1954

State File No. **27148**
3654

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3654</u>			
1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE KANSAS b. COUNTY BOURBON					
b. CITY (If outside corporate limits, write RURAL and give town or township) KANSAS CITY		c. LENGTH OF STAY (in this place) 3 days		c. CITY OR TOWN FULTON		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural, give location) 815-0 9					
3. NAME OF DECEASED (Type or Print) a. (First) ROBERT			b. (Middle)		c. (Last) CLENDENING		4. DATE OF DEATH (Month) (Day) (Year) July 25 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 11, 1883		9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (City and State or Foreign Country) Fulton, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13a. FATHER'S NAME John Clendening			13b. MOTHER'S MAIDEN NAME Kate Angle		14. NAME OF HUSBAND OR WIFE Hazel Clendening				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS VA HOSPITAL OFFICIAL RECORDS, KCMO					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain concussion with hemorrhage				DUPLICATE (b) Fall on head				3 days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUPLICATE (c)				3 days	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				Anemia				E90⁰⁰ 21	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Bourbon 816 Kansas					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 22, 1954 6PM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Slipped and fell down Steps of Porch					
22. I hereby certify that I attended the deceased from July 23, 1954 , to July 25, 1954 , that death occurred and that death occurred at 11:00a m. , from the causes and on the date stated above.									
23a. SIGNATURE <i>D. M. Miller</i> (Degree of title) D. M. MILLER, M. D.				23b. ADDRESS VA Hospital, Kansas City, Mo.		23c. DATE SIGNED 7-25-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE JULY 25, 1954		24c. NAME OF CEMETERY OR CREMATORY West Liberty Cem.		24d. LOCATION (City, town, or county) (State) Bourbon Co., Kans.			
DATE REC'D BY LOCAL REG. 7-26-54		REGISTRAR'S SIGNATURE <i>Geraldine Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & MCCLURE KANSAS CITY, MISSOURI					

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 *J. S. Walton*.....

Licensed Embalmer No *277*

P. O. Address *R. C. M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(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.