THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30874
STATE FILE NUMBER

FILED OCT 7 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1033

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo.Meth.Hosp. — Length of stay in 1b: 10 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN Agency — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Robert Middle J. Last Clinton
4. DATE OF DEATH: Month Sept. Day 25 Year 1957
5. SEX male
6. COLOR OR RACE white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Oct. 26, 1878
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. employee
10b. KIND OF BUSINESS OR INDUSTRY Mfg. Company
11. BIRTHPLACE (City and state or country) Columbus, Kentucky
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William Clinton
13b. MOTHER'S MAIDEN NAME Nancy unknown
14. NAME OF HUSBAND OR WIFE Victoria
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ———
16. SOCIAL SECURITY NO. unknwon
17. INFORMANT Mrs. Robert Clinton, Address Agency, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Fracture, Left femur
DUE TO (c): 9040 20
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [X] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Patient fell in home, causing fracture Left femur
20c. TIME OF INJURY Hour 4 ~~a.m.~~ p.m. Month, Day, Year 9 20 57
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home.
20f. CITY, TOWN, OR LOCATION — COUNTY Buchanan — STATE Mo

21. I attended the deceased from 9/20/57, to 9/25/57 and last saw ~~him~~ him alive on 9/25/57
Death occurred at 1:10a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) M.D.
22b. ADDRESS 420 N. 8th St Joseph Mo
22c. DATE SIGNED 9/26/57

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 9/27/1957
23c. NAME OF CEMETERY OR CREMATORY Agency Cemetery
23d. LOCATION (City, town, or county) Agency, Missouri (State)

24. FUNERAL DIRECTOR Heaton-Borman — ADDRESS St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG. Sept. 30, 1957
26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 6th St, St Joseph

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.