

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 18 1957

44282

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5646

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>8005 MAIN STREET</u> | | Length of stay in lb <u>34 YEARS</u> | d. STREET ADDRESS (If outside, give location) <u>8005 MAIN STREET</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM A. CLOUGH</u> | | | 4. DATE OF DEATH Month Day Year <u>NOVEMBER 29, 1957</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT. 26, 1921</u> | 9. AGE (In years last birthday) <u>36</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>WYACONDA, MISSOURI</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>SAMUEL CLOUGH</u> | | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>MARY CLOUGH</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | 17. INFORMANT Address <u>VIRGIL CLOUGH, 106 W. 79th St. K.C. Mo.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> | | | | | <u>20 YRS.</u> |
| DUE TO (c) _____ | | | | | <u>331X</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC MYOCARDIAL FIBROSIS</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>Approx. Nov. 1, 57</u> to <u>Nov. 29, 1957</u> and last saw ^{her} him alive on <u>November 28, 1957</u> Death occurred at <u>5:50 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Ruth A. Hardacre M.D.</u> | | | 22b. ADDRESS <u>3300 Charlotte - K.C., Mo.</u> | | 22c. DATE SIGNED <u>11/29/57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 23b. DATE <u>Nov. 29, 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>-</u> | | 23d. LOCATION (City, town, or county) (State) <u>WYACONDA MISSOURI</u> |
| 24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS, KANSAS CITY, Mo.</u> | | ADDRESS <u>11-29-57</u> | | 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u> | |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION
Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Ruth A. Hardacre



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 Basil Honey

Licensed Embalmer No. 4724
P. O. Address K.C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.