

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018853

STATE FILE NUMBER

FILED MAY 26 1959 Registration District No. 316 Primary Registration District No. 3057 Registrar's No. 201

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Flat River		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre			Length of stay in lb 1 Month		d. STREET ADDRESS 204 Coffman		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Beulah Middle Hazel Last Clifton				4. DATE OF DEATH Month May Day 15 Year 1959							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> / WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14, 1903		9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Perry County, Mo.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Fred Carson					14. MOTHER'S MAIDEN NAME Mary Hart						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Wm. P. Clifton, Flat River, Mo						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon										INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b)	
										DUE TO (c)	
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 <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 a. m. p. m.											
20d. INJURY OCCURRED WHILE AT WORK <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 4/24/59 to 5/15/59 and last saw her ^{her} _{twice} alive on 5/15/59 Death occurred at 11:50P on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>David W. Sawyer, M.D.</i> (Degree or title)						22b. ADDRESS /Bonne Terre, Mo.			22c. DATE SIGNED 5/21/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/18/1959		23c. NAME OF CEMETERY OR CREMATORY St. Francois Mem. Park			23d. LOCATION (City, town, or county) (State) St. Francois Co. Mo				
24. FUNERAL DIRECTOR C.Z. Boyer & Son				ADDRESS Desloge, Mo.		25. DATE RECD. BY LOCAL REG. May 22, 1959		26. REGISTRAR'S SIGNATURE <i>Esther Rudloff</i>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes.

DR. VAN W TAYLOR

6961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *B. T. Boyed*

Licensed Embalmer No. *30*

P. O. Address *Des Moines*

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.