

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025750

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District **1003** Registrar's No. **6562** STATE FILE NUMBER

FILED JUN 28 1963

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
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 2 **40003**
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52
 USE BLACK INK OR TYPEWRITER RIBBON
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis		c. CITY OR TOWN Affton		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 448 Tiffany Dr.			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Connie Clifton			First	Middle	Last	4. DATE OF DEATH Month June Day 21 Year 1963			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1895	9. AGE (last birthday) 68	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (City and state or country) Corinth, Miss.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Corinth, Miss.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Taylor Sweat			13b. MOTHER'S MAIDEN NAME Sarah West			14. NAME OF HUSBAND OR WIFE Late Otis Clifton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mildred C. Spruill 448 Tiffany Dr.				
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma right lung with metastases							INTERVAL BETWEEN ONSET AND DEATH Approx. 6 mons.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) 162-1		
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ s.m. _____ p.m.		Month, Day, Year							
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 10/9/62 to 6/21/63 and last saw her xxx alive on 6/21/63 Death occurred at 9:00 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>F.R. Bradley, M.D.</i> (Degree or title)				22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 6/21/63		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
Removal (RAIL)		June 22, 1963				Corinth, Miss.			
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.					25. DATE RECD. BY LOCAL REG. JUN 22 1963		26. REGISTRAR'S SIGNATURE <i>Boad Smith, M.D.</i>		

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 James R. Dunn
Licensed Embalmer No. 4527

P. O. Address _____

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.