

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033407

STATE FILE NUMBER

FILED OCT 14 1958 Registration District No. 179 Primary Registration District No. 4292 Registrar's No. 177

S. 300
1-57
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1. PLACE OF DEATH a. COUNTY LINCOLN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY LINCOLN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WINFIELD		c. CITY OR TOWN Winfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) THOMAS WILLEY CLOWERS		4. DATE OF DEATH OCT. 6, 1958	
5. SEX Male	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 JULY 7, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISHERMAN		11. BIRTHPLACE (City and state or country) HAMBURG, ILLINOIS	
13a. FATHER'S NAME ? CLOWERS		14. NAME OF HUSBAND OR WIFE LENORA CLOWERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT GEO. CLOWERS - FOLEY, 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) Acute Respiratory Failure			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 2 1/2 hrs not known
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Massive Cerebral Hemorrhage with Hemiplegia			
DUE TO (c) Arterio-sclerosis & Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			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 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 Oct 6, 1958 to Oct 6, 1958 and last saw the him alive on Oct 6, 1958 Death occurred at Mo. m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Frank L. Sutton, D.O., 2		22b. ADDRESS Winfield, Mo.	
22c. DATE SIGNED 10/8/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/8/58	
23c. NAME OF CEMETERY OR CREMATORY WINFIELD		23d. LOCATION (City, town, or county) (State) WINFIELD, Mo.	
24. FUNERAL DIRECTOR O. C. RICKS - ELSBERRY, Mo.		25. DATE RECD. BY LOCAL REG. 10-10-58	
26. REGISTRAR'S SIGNATURE Charlotte Beck			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *O. J. ...*

Licensed Embalmer No. *4012*
P. O. Address *E. L. Berry*

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.