FILED MAY 12 1970

DEPARTMENT OF PUBLIC HEALTH AND WELFARE – MISSOURI DIVISION OF HEALTH
(PHYSICIAN OR CORONER)

CERTIFICATE OF DEATH

STATE FILE NUMBER 124 70 0016289

DO NOT WRITE ON THIS STUB

VS 300 Rev. 1/70

Registration District No. 160 Primary Registration District No. 35592 Registrar's No. 81

9. 0
10a. 62
10b.
11. 0
12. 1
13. 4109
14.
15. 4
16.
17.
18. 0
19. CREDITS
20. 1-0

4. 0500
5. 01
6. 0506

DECEASED

1. Clifford John CLEEK
2. SEX: M
3. DATE OF DEATH (MONTH, DAY, YEAR): May 7, 1970
4. RACE (WHITE, NEGRO, AMERICAN INDIAN, ETC.) (SPECIFY): White
5a. AGE—LAST BIRTHDAY (YEARS): 62
5b. UNDER 1 YEAR: MOS. / DAYS
5c. UNDER 1 DAY: HOURS / MIN.
6. DATE OF BIRTH (MONTH, DAY, YEAR): May 3, 1908
7d. COUNTY OF DEATH: Jefferson
7b. CITY, TOWN, OR LOCATION OF DEATH: Rural Joachim Twp.
7c. INSIDE CITY LIMITS (SPECIFY YES OR NO): No
7d. HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): Jefferson Memorial Hospital
8. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): Missouri
9. CITIZEN OF WHAT COUNTRY: USA
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): Married
11. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME): Estelle Murphy
12. SOCIAL SECURITY NUMBER: 497-10-1865
13a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED): Watchman
13b. KIND OF BUSINESS OR INDUSTRY: Industrial Plant

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

14a. RESIDENCE—STATE: Mo.
14b. COUNTY: Jefferson
14c. CITY, TOWN, OR LOCATION: Festus
14d. INSIDE CITY LIMITS (SPECIFY YES OR NO): Yes
14e. STREET AND NUMBER: 208 N. Adams

PARENTS

15. FATHER—NAME (FIRST, MIDDLE, LAST): W. A. Cleek
16. MOTHER—MAIDEN NAME (FIRST, MIDDLE, LAST): Lucy - Long

17a. INFORMANT—NAME: Mrs. Estelle Cleek
17b. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): 208 N. Adams, Festus, Mo. 63028

CAUSE

PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)

18. IMMEDIATE CAUSE
(a) Cardiac arrest — DUE TO, OR AS A CONSEQUENCE OF: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 min
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST
(b) Acute anterolateral myocardial infarction 8 days — DUE TO, OR AS A CONSEQUENCE OF:
(c) Coronary atherosclerotic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a).
Acute inferior wall infarction 1969
19a. AUTOPSY (YES OR NO): NO
19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH

20a. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY)
20b. DATE OF INJURY (MONTH, DAY, YEAR)
20c. HOUR
20d. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18)
20e. INJURY AT WORK (SPECIFY YES OR NO)
20f. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY)
20g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE)
20h. IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS ☐ YES ☐ NO ☐ UNK

CERTIFIER

21a. CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM: 7 1 69
21b. TO: 5 7 70
21c. AND LAST SAW HIM/HER ALIVE ON: 5 6 70
21d. I DID/DID NOT VIEW THE BODY AFTER DEATH: DID
21e. DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED. (HOUR): 1:30 M.

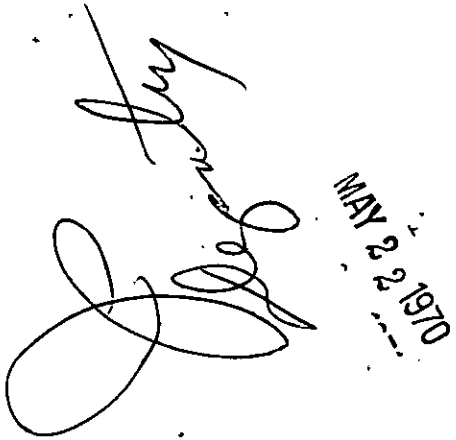
22a. CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. HOUR OF DEATH: M.
22b. THE DECEDENT WAS PRONOUNCED DEAD: MONTH 5 DAY 7 YEAR 70 HOUR: M.

23a. CERTIFIER—NAME (TYPE OR PRINT): David S. Glasgow, M.D.
23b. SIGNATURE: David Glasgow
DEGREE OR TITLE: M.D.
23c. DATE SIGNED (MONTH, DAY, YEAR): 5/7/70
23d. MAILING ADDRESS—CERTIFIER: 113 Mississippi Avenue — STREET OR R.F.D. NO. — Crystal City — CITY OR TOWN — Missouri — STATE — 63019

BURIAL

24a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal/Burial
24b. CEMETERY OR CREMATORY—NAME: Old Bonne Terre Cemetery
24c. LOCATION: Bonne Terre, Mo. (CITY OR TOWN, STATE)
24d. DATE (MONTH, DAY, YEAR): May 9, 1970
25a. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): Vinyard Funeral Home, Box 271, Festus, Mo. 63028
25b. FUNERAL DIRECTOR—SIGNATURE: Donald H Vinyard
REGISTRAR—SIGNATURE: Irene G. Ingram By Deputy
26b. DATE RECEIVED BY LOCAL REGISTRAR: 5-9-70

Type or print in PERMANENT BLACK INK. See handbook for instructions.



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_____ Signed Keith B. Vaughn

Signature of Student Embalmer

Licensed Embalmer No. 4976

P. O. Address Foxboro, Mass

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.