

SEP 26 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

27733

1. PLACE OF DEATH
 County St. Francois Registration District No. 273
 Township Farmington Primary Registration District No. 4464
 City Farmington (No. _____) St. _____ Ward _____

2. FULL NAME Louis Henry Cleve
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE W
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Hildebricht
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-14-1868
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 4 3
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Francois (STATE OR COUNTRY) Mo
 10. NAME OF FATHER Louis H Cleve
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER Louise Ricks
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Walter Cleve
 (Address) Farmington R#1
 15. FILED Aug 19 1930 R. J. Robinson REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 17 - 1930
 17. I HEREBY CERTIFY, That I attended deceased from June 30 1930 to June 15 1930 that I last saw him alive on Aug 8 1930, and that death occurred, on the date stated above, at 4 2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Descending myelitis SIA
Chronic Portalis 127
Nemias 1325

CONTRIBUTORY (SECONDARY) 17500
 (duration) yrs. mos. ds.
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Same
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS Cleaves
 (Signed) R Appberry, M. D.
Aug 18, 1930 (Address) Farmington Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Southern Cemetery DATE OF BURIAL Aug 19 1930
 20. UNDERTAKER Heidert mch co ADDRESS Farmington

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

