

DEC'D AUG 8 1938

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

24425  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 377  
(b) Township Yan Primary Registration District No. 1002 Registered No. 2930  
(c) City Yan (d) Street No. 420 St. Gen Hosp.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 903 1/2 E 31st St St.  (Usual place of abode, if no street address, write county or city)  
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Calla Cloud

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 9 1881

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
56 7 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

FATHER 13. NAME James F. Cloud

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

MOTHER 15. MAIDEN NAME unmarried

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unmarried

17. INFORMANT (ADDRESS) Preach Clerk

18. BURIAL, CREMATION OR REINTERMENT Gen Hosp

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Peter Campbell

20. FILED July 21 1938 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-21 1938

22. I HEREBY CERTIFY, That I attended deceased from 9-19 1938 to 7-21 38  
I last saw him alive on 7-21 1938 Death is said to have occurred on the date stated above, and 6:16 a.m.  
The principal cause of death and related causes of importance were as follows:

Coronary sclerosis Date of onset  
Ante myocardial  
thrombosis 44d.  
Other contributory causes of importance:  
Pneumonia

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
(Signed) J. D. Maria M. D.  
(Address) Gen Hosp

N. B.—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.

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**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.**