DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43442

Registration District No. 318 Primary Registration District No. 5440 Registrar's No. 921 "A"

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Medical Center for Federal Prisoners 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Yr. 1Mo. 22days (Specify whether
In this community Same
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 2

(a) State Florida (b) County

(c) City or town Pensacola, Florida
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME CLEVELAND, Gaylie R. 414

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Sara Elliot Levis

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased November (Month) 6th (Day) 1873 (Year)

8. AGE: Years 66 Months 1 Days 13 If less than one day hr. min.

9. Birthplace Becoiah, (City, town, or county) Iowa (State or foreign country)

10. Usual occupation Laborer 1

11. Industry or business

FATHER
12. Name Unknown 4
13. Birthplace Unknown (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Deceased

(b) Address

17. (a) Springfield, Mo. (Burial, cremation, or removal) (b) Date thereof 12-~~23~~ 22-39 (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cem Springfield, Mo.

18. (a) Signature of funeral director Thieme Funeral Home

(b) Address Springfield, Mo.

19. (a) 12/21/39 (Date received local registrar) (b) Chas. A. George M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19th year 1939 hour 3:45 minute A.M.

21. I hereby certify that I attended the deceased from Oct. 27, 1938, 19__, to Dec. 19, 1939, that I last saw him alive on December 19, 1939, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Nephritis, chronic, interstitial	Unknown
Due to 21	
Due to	
Other conditions Uremia, pulmonary, edema (Include pregnancy within 3 months of death)	Unknown

Major findings:
Of operations

Of autopsy Yes, Chronic, interstitial nephritis; pulmonary edema

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) -

(b) Date of occurrence -

(c) Where did injury occur? - (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? No (e) Means of injury

23. Signature C. S. Sample (M. D. or other) 1

Address M.C.F.P. Springfield, Mo. Date signed 12/20/39

(Licensed Embalmer's Statement on Reverse Side)

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.

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

Signed Ralph Thieme

Licensed Embalmer No. 3681

P. O. Address Sp. Va.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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