

1941 JUN 3 1941

FIVE JUN 3 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **18492**

Registration District No. 591

Primary Registration District No. 5789

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Montgomery  
(b) City or town Bellflower (Rural)  
(c) Name of hospital or institution: \*/  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \*/  
In this community Life 9 Months  
years, months or days

3. (a) PRINT FULL NAME William Dale Cluster

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 \*/

6. (b) Name of husband or wife \*/ 6. (c) Age of husband or wife if alive \*/ years

7. Birth date of deceased 7 29 1940  
(Month) (Day) (Year)

8. AGE: Years 0 Months 9 Days 0 If less than one day hr. \*/ min.

9. Birthplace Middletown Mo. (City, town, or county) (State or foreign country)

10. Usual occupation \*/

11. Industry or business \*/

MOTHER { 12. Name Wilber Cluster  
FATHER { 13. Birthplace Middletown Mo. (City, town, or county) (State or foreign country)  
14. Maiden name Abbie Moore  
15. Birthplace Bellflower Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Wilber Cluster  
(b) Address Bellflower Mo R.F.D.

17. (a) Burial (b) Date thereof 4/30/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Macedonia Cem

18. (a) Signature of funeral director Oland J. Smith  
(b) Address Bellflower Mo

19. (a) May 1 - 41 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery  
(c) City or town Bellflower (Rural)  
(d) Street No. Prairie Township  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 29 year 1941 hour 10 minute 0 M.

21. I hereby certify that I attended the deceased from Apr. 21, 41 to Apr. 29, 41 that I last saw him alive on Apr. 29, 41 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

521 While at work? (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) 0  
Address Cooney, Mo. Date signed 4-27-41

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 Cedric H. Jones, Registered Apprentice No. 246 working under my personal supervision.

Signed Cland A. Jones  
Licensed Embalmer No. 2978

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18492

Registration District No. 291

Primary Registration District No. 5789

Registrar's No.

1. PLACE OF DEATH

(a) County Montgomery

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

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Wm Dale Claster

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Aug day 29  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration \_\_\_\_\_

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

Due to Bronchial preceded by an  
attack of Bronchial  
Pneumonia 3mos. before

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

Due to \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 5 months of death)

11. Industry or business \_\_\_\_\_

Major findings: \_\_\_\_\_

12. Name \_\_\_\_\_

Of operations \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

Of autopsy \_\_\_\_\_

14. Maiden name \_\_\_\_\_ (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. J. Dunn (M. D. or other) \_\_\_\_\_

Address Elroy Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

S-18492 1941