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NOTED JUL 24 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22445**

Registration District No. **703**

Primary Registration District No. **4424**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Polk**

(b) City or town **Humansville**
(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)

3. (a) PRINT FULL NAME **John W. Cloud**

3. (b) If veteran, name war **Indian War**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of ~~husband~~ wife **Nancy**

6. (c) Age of husband or wife if alive _____ years _____ (Day) _____ (Year)

7. Birth date of deceased **Sept 4 1869**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	71	10	2	_____ hr. _____ min.

9. Birthplace **Mill River / Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name **John Cloud**

13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Nancy F. Cloud**

(b) Address **Humansville, Mo.**

17. (a) **Burial** (b) Date thereof **July 10-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Humansville Cemetery**

18. (a) Signature of funeral director **Joseph & Firestone**

(b) Address **Humansville, Mo.**

19. (a) **July 10-41** (b) **ORA M. RICH**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Polk** **84**

(c) City or town **Humansville** **0**
(If outside city or town limits, write "RURAL") **0**

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

(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **6**
year **1941** hour **8** minute **15 A.M.**

21. I hereby certify that I attended the deceased from _____
19**35** to **July 6** 19**41**
that I last saw him alive on **July 3** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** **20min**
Duration

Due to **had asthma**

Due to **for years**

Other conditions **gfh**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

632 (Specify type of place) _____
While at work? _____ (a) Means of injury _____

23. Signature **Roseog @ Neums** (M. D. or other) **M.D.**

Address **Humansville Mo** Date signed **7-9-41**

JUL 22 1941

AUG 8 1941

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.....

Charles G. Hathaway

, Registered Apprentice No. *269*

working under my personal supervision.

Signed.....

Ralph A. Joseph

Licensed Embalmer No. *3189*

P. O. Address. *Humansville*

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

If this body is not embalmed, fact should be so stated above.

Registration District No. 703

Primary Registration District No. 4424

Registrar's No. _____

1. PLACE OF DEATH: Palk

(a) County _____

(b) City or town _____
(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 years, months or days)

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 John W. Cloud

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH month July day 6
year 1951 hour _____ minute _____ M.

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

4. Sex m 5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept 4 - 1869
(Month) (Day) (Year)

ImmEDIATE cause of death _____

Duration _____

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

Due to _____

Due to _____

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

10. Usual occupation Invalid for 15 years

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant _____
(b) Address _____

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

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

(b) Date of occurrence _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

(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? _____

18. (a) Signature of funeral director _____
(b) Address _____

While at work? _____
(Specify type of place) (c) Means of injury

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

S-22445

SECRET