

No. 2
4-13-40
5-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30057**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7396**

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St Louis**
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 mo 17 das**
In this community **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Wilford Cloyd**
3. (b) If veteran, name war.....
3. (c) Social Security No. **498-07-9601**

4. Sex **Male** Color or race **W.C.**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Birdie**
6. (c) Age of husband or wife if alive **unk** years

7. Birth date of deceased **June 30 1897**
(Month) (Day) (Year)

8. AGE: Years **44** Months **2** Days **9**
If less than one day hr. min.

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

10. Usual occupation **San blaster and Riveter**

11. Industry or business.....

MOTHER FATHER
12. Name **Harvey Cloyd**
13. Birthplace **Nashville Tenn**
(City, town, or county) (State or foreign country)
14. Maiden name **Willa Villars**
15. Birthplace **Madison County Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **James S. Clay**
(b) Address **4310 West Bell Pl**

17. (a) **Burial** (b) Date thereof **Sept 13-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **J. H. Beale**
(b) Address **3133 Bell Ave**

19. (a) **SEP 13 1941** (b) **J. P. Beebeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **17**
(c) City or town **St Louis** (If outside city or town limits, write "RURAL") **11 9**
(d) Street No. **4310 West Belle** (If rural, give location)
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **9**
year **1941** hour **2:30** minute **P** M.

21. I hereby certify that I attended the deceased from **July 22** 19**41** to **September 9** 19**41**; that I last saw him alive on **September 9** 19**41**; and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis** Prob **2** years

Due to.....
Due to.....

Other conditions (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?

While at work? (Specify type of place) (e) Means of injury.....
23. Signature **J. W. Johnson** (M. D. or other) **11**
Address **2601 N Whittier** Date signed **9-10-41**

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, ~~by~~.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

S. J. Watson

Licensed Embalmer No.....

2498

P. O. Address.....

2769 Chautauque

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, fact should be so stated above.