

S. No. 2
5-42
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18515**

FILED JUN 14 1943

Registration District No. **245**

Primary Registration District No. **3047**

Registrar's No. **52**

1. PLACE OF DEATH: **Newton**

(a) County.....**Newton**

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

(c) Name of hospital or institution:
314 W. McKinney
(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.....**Missouri** (b) County.....**Newton**

(c) City or town.....**Neosho**
(If outside city or town limits, write "RURAL")

(d) Street No. **#314 West McKinney**
(If rural, give location)

(e) Citizen of foreign country?.....
(Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **Carrie June Cloud**

3. (b) If veteran, name war..... No.....

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

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**

6. (b) Name of husband or wife **H.A.F. Cloud** 6. (c) Age of husband or wife if alive **51 1/2** years

7. Birth date of deceased. **June 2 1869**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **1st**
year **1943** hour **10** minute **10** a. m.

21. I hereby certify that I attended the deceased from **May 26**
19**43**, to **June 1**, 19**43**
that I last saw her alive on **June 1**, 19**43**
and that death occurred on the date and hour stated above.

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

73	11	29	hr. min.
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9. Birthplace **Johnson Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

Immediate cause of death **Cerebral hemorrhage on left side**

Due to **Arteriosclerosis**

Due to **Chronic indurated atheroma**

Other conditions (Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business.....

12. Name **Jess Faulkner**

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

14. Maiden name **Mary Dennis**

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

16. (a) Informant **Rose Carter**
Neosho Mo

(b) Address **burial**

17. (a) (b) Date thereof **June 2 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **I.O.O.F. Cemetery**

18. (a) Signature of funeral director **J. A. Bigham**
Neosho Mo

(b) Address **Neosho Mo**

19. (a) **6-3-1943** (b) **Corey Thompson**
(Date received local registrar) (Registrar's signature)

Major findings: Of operations **None**

Of autopsy **None**

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 **Melvin P. Bowman M.D.**
Neosho, Mo Date signed **June 2-43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Date Received **JUN 7 1943**

File no. 643-103

JUN 25 1943

JUN 10 1943

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 J. B. [Signature]
Licensed Embalmer No. 2689
P. O. Address [Signature]

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.