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

19238

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 8 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 337 Primary Registration District No. 6145 Registrar's No. 43

1. PLACE OF DEATH:
(a) County: Shelby Co
(b) City or town: Rural Salt River Twp
(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 ..... In this community: 36 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: ..... (b) County: 102
(c) City or town: 0
(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: 0

3. (a) PRINT FULL NAME: Ethel Cleek
3. (b) If veteran, name war: .....
3. (c) Social Security No. .....

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Rufford Cleek
6. (c) Age of husband or wife if alive: 50 years
7. Birth date of deceased: Oct (Month) 28th (Day) 1894 (Year)

8. AGE: Years 48 Months 6 Days 8 If less than one day ..... hr. ..... min.

9. Birthplace: Mc Donough Co (City, town, or county) Ill (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: .....

MOTHER FATHER
12. Name: William Mc Mahill
13. Birthplace: Mc Donough Co (City, town, or county) Ill (State or foreign country)
14. Maiden name: Arvia Bond
15. Birthplace: Warren Co (City, town, or county) Ill (State or foreign country)

16. (a) Informant: Rufford Cleek
(b) Address: Shelbina Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-8-43 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~: Shelbina Mo
18. (a) Signature of funeral director: E. Hayes
(b) Address: Shelbina Mo
19. (a) May 22-43 (Date received local registrar) (b) Madge Wood (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 6 year 1943 hour 6 minute P M.

21. I hereby certify that I attended the deceased from 5-10-1941, 19..., to 4-30-43, 19...; that I last saw he alive on 4-30-43, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cancer of Spine 5th Lumbar	2 yrs
Due to:	
Due to: metastasis from Breast	2 yrs
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 55	
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: A. M. Wood (M. D. or other)
Address: Shelbina Mo. Date signed: 5-10-43

1095

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 6-43-965
Date Filed JUN 7 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.....E Hayes.....

Licensed Embalmer No.....1437.....

P. O. Address.....Shelbina Mo

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, fact should be so stated above.

. S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 337 Primary Registration District No. 6148 Registrar's No. 43

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Shelby
(b) City or town: Rural Shelbina
(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: —
In this community (Specify whether years, months or days): 36 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: ~~Shelby Mo~~ (b) County: ~~Mo~~ Shelby
(c) City or town: Shelbina Rural
(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: Ethel Cleek

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife: Reyford

6. (c) Age of husband or wife if alive: 50 years

7. Birth date of deceased: Oct 28 (Month) — 1894 (Day) (Year)

8. AGE: Years: 48 Months: 6 Days: Hours: If less than one day: min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 4 year: 1943 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.

Immediate cause of death	Duration
Cancer of spine	2 yrs
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? (Specify type of place)
While at work? (e) Means of injury

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

S-19238