

2
2-43
7-39
K35697

FILED MAY 8 1944
Registration District No. 707

Primary Registration District No. 3032

State File No. _____

Registrar's No. 59

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Warrensburg
(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 22 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson

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

(d) Street No. 704 Highland
(If rural, give location)

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

3. (a) PRINT FULL NAME THOMAS WILLIAM CLEVELAND

3. (b) If veteran, name war _____ 3. (c) Social Security No. 500-10-7407

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

6. (b) Name of husband or wife Mattie Powell Cleveland 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased April 18, 1868
(Month) (Day) (Year)

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

76 11 11 hr. min.

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

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name James Cleveland

13. Birthplace Johnson County Mo
(City, town, or county) (State or foreign country)

14. Maiden name Farlee Williams

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

16. (a) Informant Mattie Cleveland

(b) Address 704 Highland

17. (a) Burial (b) Date thereof May 3, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Cemetery

18. (a) Signature of funeral director W. R. Wilcox

(b) Address Washington Mo.

19. (a) May 3, 1944 (b) Leola M. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29th
year 1944 hour 11 minute P.M.

21. I hereby certify that I attended the deceased from Apr 29
Apr 29 1944 to Apr 29 1944
that I last saw him alive on Apr 29 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cutting a tree in his yard a limb fell on limb breaking right leg crushing the leg

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 6 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: 05

(a) Accident, suicide, or homicide (specify) no accident

(b) Date of occurrence April 29 1944

(c) Where did injury occur at his home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at his home
(Specify type of place) (e) Means of injury

23. Signature John T. Anderson (M. D. or other) May
Address Warrensburg Date signed _____

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

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 *myself*

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Samuel M. Clune

Licensed Embalmer No.

3557

P. O. Address.....

Warrensburg Mo

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.