

FILED JAN 9 1945

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 195

Primary Registration District No. 5915

Registrar's No. 25

1. PLACE OF DEATH

(a) County Mo. Donald  
(b) City or town None  
(c) Name of hospital or institution: None  
(d) Length of stay: In hospital or institution: None  
In this community None

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County 60  
(c) City or town \_\_\_\_\_  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_

3. (a) PRINT FULL NAME

Kate L. Cleveland

3. (b) If veteran, name war

None

3. (c) Social Security No.

None

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_

5-30-1890

8. AGE:

Years 55 Months 6 Days 11 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace

Johnson Co. MO.

10. Usual occupation

Housewife

11. Industry or business

None

12. Name

Unknown

13. Birthplace

"

14. Maiden name

Unknown

15. Birthplace

"

16. (a) Informant

State Social Records

(b) Address

Mo. Donald Co.

17. (a) \_\_\_\_\_

(Burial, cremation, or removal)

(b) Date thereof

12-12-45

(c) Place: burial or cremation

Princeton

18. (a) Signature of funeral director

H. M. Murphy

(b) Address

Princeton, Mo.

19. (a) \_\_\_\_\_

(Date received local registrar)

(b) \_\_\_\_\_

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 11th year 1945 hour 10 minute 30 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 1945 to Dec. 11 1945 and that death occurred on the date and hour stated above.

Immediate cause of death

Asphyxiation pneumonia

Duration

4 days

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? \_\_\_\_\_  
(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 \_\_\_\_\_

(M. D. or other)

Address Carder, MO Date signed 12-27-45

1660

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

MOTHER FATHER

---

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

Registration District No. 175

Primary Registration District No. 5915

Registrar's No. 25

1. PLACE OF DEATH:

(a) County McDonald  
(b) City or town Rural  
(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 Kate C. Cleveland

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 W

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 30, 1898  
(Month) (Day) (Year)

8. AGE: Years 55 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Mrs. B.E. Bradley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald  
(c) City or town Jane Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

4-751