. S. No. 2
0M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33474

Registration District No. 349 Primary Registration District No. 6185 Registrar's No. 2

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Union 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 Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. Union Twp 0
(If rural, give location)

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

If yes, name country —

3. (a) PRINT FULL NAME Edith Olive Cleeton

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 widowed

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

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

7. Birth date of deceased 2 (Month) 6 (Day) 1879 (Year)

8. AGE: Years 68 Months 7 Days 12 If less than one day ..... hr. ..... min.

9. Birthplace Sullivan (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business

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

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

16. (a) Informant W. H. Cleeton
(b) Address Green City, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (Month) 20 (Day) 1947 (Year)

(c) Place: burial or cremation Owasco Cem

18. (a) Signature of funeral director Glenn E. Kent & Son
(b) Address Green City, Mo

19. (a) 10-4-47 (Date received local registrar) (b) Laura Shaw deputy (Registrar's signature) 319

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
year 1947 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from Aug 1, 1947 to Sept 18, 1947
that I last saw her alive on Sept 17, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma right ovary	1 year
Gland cell type	
~~Due to~~ free fluid abdomen county	
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 0

23. Signature T. R. Martin (M.D. or other)

Address Browning Mo Date signed Sept 19 47

(Licensed Embalmer's Statement on Reverse Side)

JAN 22 1948

RECEIVED
District Health Officer No. 10
District File Number 10:47:1367
Date Filed OCT - 7 1947

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Grand Lake, 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.