

FILED JAN 7 1949

Registration District No. **247**

Primary Registration District No. **4507**

Registrar's No. **69**

1. PLACE OF DEATH:

(a) County **Stone**
(b) City or town **Crane**
(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) **1**
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **two years** years, months or days

3. (a) PRINT FULL NAME **DAVID HUSTON CLOUD**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **431-40-0027**

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

6. (b) Name of husband or wife **Chloe Mahalia Cloud** 6. (c) Age of husband or wife if alive **38** years

7. Birth date of deceased **Oct 11 1884** (Month) (Day) (Year)

8. AGE: Years **64** Months **2** Days **17** If less than one day hr. - min.

9. Birthplace **Christian Co. Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **same**

12. Name **Joe Cloud**

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

14. Maiden name **Lotha Ellingsworth**

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

16. (a) Informant **Mrs. Chloe M. Cloud**

(b) Address **Crane Mo.**

17. (a) **Removal** (burial, cremation, or removal) (b) Date thereof **Dec. 21-48** (month) (Day) (Year)

(c) Place: burial or cremation **Burial Grandview Cem.**

18. (c) Signature of funeral director **R. J. Nelson**

(b) Address **Box 311, Berryville, Ark.**

19. (a) **Dec. 23-48** (Date received local registrar) (b) **Lena Murray, Reg.** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Stone** **104**
(c) City or town **Crane** (If outside city or town limits, write "RURAL") **1**
(d) Street No. **East meadow ave.** (If rural, give location) **0**
(e) Citizen of foreign country? **No.** (Yes or No) **0**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **18** year **1948** hour **8** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Oct 25 - 1948** to **Dec 18 - 1948** that I last saw him alive on **Dec 17 - 1948** and that death occurred on the date and hour stated above.

Immediate cause of death **myocarditis**
Due to **mitral valve disease**
Due to **Rheumatic heart disease**

Duration
1 3/4
30 yr.
35 yr.

Other conditions **none** (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? _____
While at work? _____ (Specify type of place) (c) Means of injury **0**

23. Signature **H. L. Kerr** (M. D. or other) Address **Crane Mo.** Date signed **12-19-48**

RECEIVED

District Health Officer No. 6,

District File Number 149-12

Date Filed 1-5-48

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 R. L. Nelson

Licensed Embalmer No. 2992

P. O. Address Berrysville

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.