

FILED AUG 24 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25950

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 233

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kirksville</u>	c. LENGTH OF STAY (in this place) <u>1 hr 45 m.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Winigan</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Grim-Smith Memorial Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>/</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Floyd</u> b. (Middle) _____ c. (Last) <u>Cleeton</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 8 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 24, 1875</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u>	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County Judge</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Sullivan County, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Wesley Cleeton</u>	13b. MOTHER'S MAIDEN NAME <u>Magara Cleeton</u>	14. NAME OF HUSBAND OR WIFE <u>Allie Cleeton</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Allie Ellone Cleeton</u>	ADDRESS <u>Winigan, Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary embolus</u>		<u>30 min.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		<u>3 mos.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>4222</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>SUICIDE</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Aug 7, 1949, to Aug 8, 1949, that I last saw the deceased alive on Aug 8, 1949, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Orlton T. Engler, M.D.</u>	23b. ADDRESS <u>1111 N. Main St., Kirksville, Missouri</u>	23c. DATE SIGNED <u>Aug 8, 1949</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 10 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ourasco</u>	24d. LOCATION (City, town, or county) (State) <u>Sullivan Co Mo</u>
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DATE REC'D BY LOCAL REG. <u>8-8-49</u>	REGISTRAR'S SIGNATURE <u>Nate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn E. Kent</u>	ADDRESS <u>1111 N. Main St., Kirksville, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED AUG 22 1949  
District Health Officer No. 10  
District File Number 2-49-12  
Date Filed AUG 22 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

Working under my personal supervision.

Signed Archie W. Wade

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3037

P. O. Address Grew City, 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.