

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

7381

BIRTH NO. _____		REG. DIST. NO. <u>42</u>	PRIMARY REG. DIST. NO. <u>1000</u>	Registrar's No. <u>327</u>
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Iowa</u> b. COUNTY <u>Taylor</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Blockton</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Parkview Nursing Home 1006 Newey St.</u>		d. STREET ADDRESS (If rural, give location) <u>8140</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u>		b. (Middle) <u>S.</u>		c. (Last) <u>Cloos</u>
4. DATE OF DEATH (Month) (Day) (Year) <u>March 23, 1952</u>		5. SEX <u>female</u>		
6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>July 25, 1874</u>
9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Grant City, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Henry Stabe</u>		
13b. MOTHER'S MAIDEN NAME <u>Barbar Hays</u>		14. NAME OF HUSBAND OR WIFE <u>William Cloos</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. F. O. Davis</u> ADDRESS <u>415 N. 10th. St. Joseph, Mo.</u>
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4500</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <u>3/23, 1952</u> , to <u>3/23, 1952</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:04 am</u> m., from the causes and on the date stated above.				
23a. SIGNATURE <u>Dr. C. Benson</u> (Degree or title)		23b. ADDRESS <u>M.D. 509 Corby Bldg</u>		23c. DATE SIGNED <u>3/27/52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3/23/1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Grant City</u> (State) <u>Missouri</u>
DATE REC'D BY LOCAL REG. <u>MAR 28, 1952</u>		REGISTRAR'S SIGNATURE <u>Carl C. Cash</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Neaton Bowman Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u>

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

21174

Dr. Berman

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.

Student
Student Embalmer

Signed *James B. Hawkins*
Licensed Embalmer No. 4586

P. O. Address *St. Joseph, 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.