

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **2953**  
**0248**  
Registrar's No. ....

FILED JAN 28 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		8410	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)		8	
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)	
John		P.		Cloud	
4. DATE OF DEATH		5. SEX		6. COLOR OR RACE	
Jan 8. 1953		Male		White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years) Last birthday	
Widowed		Sep 15. 1868		84	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)	
Farmer				Illinois / U.S.A	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
Benjamin Cloud		Unknown		Emma Cloud	
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	
No		None		Mazie Stuber 4708 Genevieve	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Lobar pneumonia			2 days
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS			
II. ANTECEDENT CAUSES		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) Myocarditis Ch.			
		DUE TO (c) Oysterio-Sclerain			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" 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)	
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? 490x	
22. I hereby certify that I attended the deceased from 12/28 1953, to 1/8 1953, that I last saw the deceased alive on 1/8/53, 1953, and that death occurred at 4:30 p.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title)		23b. ADDRESS		23c. DATE SIGNED	
M. J. Waggenbach		4.717 Morganford		1/9/53	
24a. BURIAL, CREMATION REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY	
Removal		1-9-53		Tiptonville Tenn	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
JAN 9 1953		Albert H. Hoppe 4700 Washington			

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

32

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 Paul J. Farmer

Licensed Embalmer No. 4788

P. O. Address St. Louis 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.