

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **9401**

FILED APR 6 1953

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **340**

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield 0396	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 1608 W. Brower	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1608 W. Brower			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			
a. (First) OLIVE	b. (Middle) PEARL	c. (Last) GLOVEN	(Month) March	(Day) 31	(Year) 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 29 Sept. 1890	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In home	11. BIRTHPLACE (State or foreign country) Missouri U		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Amos Pruett	13b. MOTHER'S MAIDEN NAME Parker	14. NAME OF HUSBAND OR WIFE George T. Cloven
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME George T. Cloven ADDRESS Springfield, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Epidemioid Carcinoma of Basal		DUCE TO (b) Incess with cervical and mediastinal metastases		6 mo.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUCE 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 1444X	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)
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 **Feb 1**, 19**53**, to **March 31**, 19**53**, that I last saw the deceased alive on **March 29**, 19**53**, and that death occurred at **6:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Thomas S. Ashley M.D. (Degree or title)	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 4-1-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-3-53	24c. NAME OF CEMETERY OR CREMATORIUM COTTER CEMETERY
		24d. LOCATION (City, town, or county) (State) Gottes Arkansas

DATE REC'D BY LOCAL REG. 4-2-53	REGISTRAR'S SIGNATURE Edwin Williamson Reg.	25. FUNERAL DIRECTOR'S SIGNATURE J.W. KLINGNER & CO. ADDRESS Springfield, Mo.
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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 Ogle Stone Jr

Licensed Embalmer No. 4176

P. O. Address Springfield

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.