

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044035  
STATE FILE NUMBER  
6176

FILED JAN 14 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Town Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Overland Park</b> <sup>9150</sup> <sub>8</sub> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Length of stay in lb <del>5 years</del> <b>6 days</b>	d. STREET ADDRESS (If outside, give location) <b>8921 Goodman</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>IVAN</b> Middle <b>FRANKLIN</b> Last <b>CLOUD, SR.</b>			4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1958</b>		
--	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1887</b>	9. AGE (In years last birthday) <b>71</b>	FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---	---	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Printer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	11. BIRTHPLACE (City and state or country) <b>Allendale, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
---	--	--	---

13a. FATHER'S NAME <b>Frank Cloud</b>	13b. MOTHER'S MAIDEN NAME <b>Ella Harroum</b>	14. NAME OF HUSBAND OR WIFE <b>Evall Cloud</b>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>487-07-6736</b>	17. INFORMANT Address <b>Ivan F. Cloud, Jr. 6435 College, Kansas City</b>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of Stomach</b>		
DUE TO (c) <b>151*</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Malnutrition; Arteriosclerosis; Coronary Occlusion</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	---	--	---

21. I attended the deceased from <b>May 1955</b> to <b>12/26/58</b> and last saw her alive on <b>12/26/58</b> Death occurred at <b>5:30 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) <b>Paul B. Burger, M.D.</b>	22b. ADDRESS <b>6949 Neman - Shawnee, Ks.</b>	22c. DATE SIGNED <b>12/28/58</b>
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 29, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ozark Memorial Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Joplin Missouri</b>
--	-----------------------------------	--	---

24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons, Kansas City, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>12-29-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Paul B. Burger

All diseases in Part I must be causally related.

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 .....

Signature of Student Embalmer

Signed *James W. Rosen* .....

Licensed Embalmer No. *7089* .....

P. O. Address *D.C. Md.* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.