

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000101  
STATE FILE NUMBER

FILED JAN 29 1959

Registration District No. 10 Primary Registration District No. 5037 Registrar's No. 21

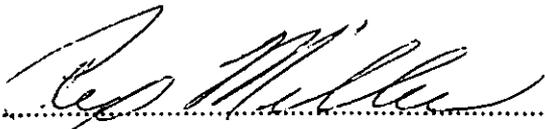
All diseases in Part I must be causally related.  
 11-19. S.W.A. WE DRY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Audrain</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Audrain</b> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Salt River Township</b>   |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | c. CITY OR TOWN <b>Mexico</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR At Home <b>RFD 1</b><br>INSTITUTION <b>Mexico, Mo.</b>   |                                  | Length of stay in lb<br><b>1</b> yrs  | d. STREET ADDRESS (If outside, give location)<br><b>R. F. D. 1</b>   |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>             |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Joseph</b> Middle <b>Frank</b> Last <b>Cleeton</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>21</b> Year <b>1959</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 9, 1891</b>   |  | 9. AGE (In years last birthday)<br><b>67</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>General</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Audrain County, Mo.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13a. FATHER'S NAME<br><b>Thomas Cleeton</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Elizabeth Shock</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Catherine Cleeton</b>                            |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>499-30-6918</b>   |  | 17. INFORMANT<br>Address <b>RFD 1</b><br><b>Mrs. Catherine Cleeton Mexico, Mo.</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Embolism</b>   |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 years</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary Artery disease</b>  |                                  |   |  |  | <b>7 years</b>  |
| DUE TO (c) _____  |                                  |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>4261</b>  |                                  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |                                  |   |  |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <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>11-20-1951</b> to <b>1-21-59</b> and last saw <sup>her</sup> him alive on <b>1-10-59</b><br>Death occurred at <b>3:45 pm</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |  |   |
| 22a. SIGNATURE<br><b>H. L. Swan 100</b> (Degree or title)   |                                  |   | 22b. ADDRESS<br><b>Mexico Mo</b>   |  | 22c. DATE SIGNED<br><b>1-23-59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>1-24-1959</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Hope Cemetery</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Audrain County, Missouri</b>                  |
| 24. FUNERAL DIRECTOR<br><b>Arnold Funeral Home Mexico, Mo.</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>Jan 23-1959</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Blanche Neely</b>                                  |   |

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  .....

Licensed Embalmer No. ....

P. O. Address  .....

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.