

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-041025

STATE FILE NUMBER

FILED VS NOV 17 1959

Registration District No. 218

Primary Registration District No. 5789

Registrar's No. 32

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>MISSISSIPPI</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>MISS.</b>		
b. CITY OR TOWN <b>EAST PRAIRIE</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>EAST PRAIRIE</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>AT HOME</b>		Length of stay in lb <b>2 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>RURAL ROUTE 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>DELPHA LUCILLE Mc CLOUD</b>			4. DATE OF DEATH Month Day Year <b>OCT. 31-1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13-1920</b>		9. AGE (In years last birthday) <b>39</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>KIEFER OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>WALTER WILLIAMS</b>		13b. MOTHER'S MAIDEN NAME <b>ROSA ESTES</b>		14. NAME OF HUSBAND OR WIFE <b>WILLIAM J. Mc 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>432-64-4994</b>		17. INFORMANT Address <b>William J. Mc Cloud East prairie mo. 2</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>Myocardial Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Circumstances of Term</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) <b>174X</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs.</b> <b>6 mo.</b>
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 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>Sept 12</b> to <b>Oct 31</b> and last saw <sup>per him</sup> <b>Oct 27</b> Death occurred at <b>9:08 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>W. H. Sudders M.D.</b>			22b. ADDRESS <b>East Prairie Mo.</b>		22c. DATE SIGNED <b>11/5/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11-2-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Manila Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Manila aut. Mo.</b>
24. FUNERAL DIRECTOR <b>HOWARD FUNERAL SERVICE MANILA MO.</b>		ADDRESS <b>MANILA MO.</b>		25. DATE RECD. BY LOCAL REG. <b>11-12-59</b>	26. REGISTRAR'S SIGNATURE <b>Leatrice G. Harper</b>

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

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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 .....  
Signature of Student Embalmer

Signed *W. F. Howard* .....

Licensed Embalmer No. *3959* .....

P. O. Address *Beaumont, Tex., Ar* .....

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.