

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 2 1960

-60-009571
STATE FILE NUMBER

Registration District No. 952 Primary Registration District No. 4521 Registrar's No. 20

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Texas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Houston</u>		Length of stay in 1b		c. CITY OR TOWN <u>Summersville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Texas Co Mem. Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u></u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Marion</u> Last <u>Cleaver</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1960</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8/24/75</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>Hartsville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>James Cleaver</u>			13b. MOTHER'S MAIDEN NAME <u>Louisa Hodge</u>			14. NAME OF HUSBAND OR WIFE <u></u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Eugene F. Cleaver Summersville, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of Myocardium</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? 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.) <u></u>					
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>								
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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u>		STATE <u></u>	
21. I attended the deceased from <u>Feb. 13, 1960</u> to <u>Feb 15, 1960</u> and last saw <u>him</u> alive on <u>Feb 15, 1960</u> Death occurred at <u>9:55 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Joe A. Wall MD</u>				22b. ADDRESS <u>Houston, Missouri</u>			22c. DATE SIGNED <u>2-16-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/17/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Side Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Mountain View, Mo.</u>				
24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mtn. View, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Feb. 24-60</u>		26. REGISTRAR'S SIGNATURE <u>Myrtle Craig</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Richard A. Norton

Licensed Embalmer No. 502

P. O. Address Mt. Vernon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.