

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030358

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Registration District No. _____ Primary Registration District No. **3024** Registrar's No. **86**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Missouri		Length of stay in 1b 8 weeks	c. CITY OR TOWN Rocheport Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lee Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First DEAN Middle LEOTA Last CLEVELAND	4. DATE OF DEATH Month AUGUST Day 29 , Year 1960
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/22/1880	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) House work	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Newark, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John T. Means	13b. MOTHER'S MAIDEN NAME Mahala Rarick	14. NAME OF HUSBAND OR WIFE James W. Cleveland
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. 473-24-0751	17. INFORMANT Ammy Gardner, Rocheport, Mo. Address _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease		INTERVAL BETWEEN ONSET AND DEATH 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e.g., Diabetes mellitus & cerebral vascular disease)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) None
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year Aug 29, 1960	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 1958 to Aug 29, 1960 and last saw ^(her) her alive on Aug 29, 1960 Death occurred at 12 noon m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Wm J. Shan, Jr M.D.	22b. ADDRESS Lee Hospital, Fayette, Mo	22c. DATE SIGNED 8-30-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/1/1960	23c. NAME OF CEMETERY OR CREMATORY Cory Grove Cemetery	23d. LOCATION (City, town, or county) (State) Sac City, Iowa
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24. FUNERAL DIRECTOR Ralph A. Carr ADDRESS Fayette, Mo.	25. DATE RECD. BY LOCAL REG. 8-30-60	26. REGISTRAR'S SIGNATURE Katherine Welch
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

