

1830 JUN 21 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

18733

Do not use this space.

1. PLACE OF DEATH
 (a) County HENRY Registration District No. 397
 (b) Township CLINTON Primary Registration District No. 3018
 (c) City CLINTON (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JOHN ALVIN CLOE
 (a) Residence, No. 327 N WASHINGTON (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hattie Cloe

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-26-1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
52 11 23

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Section man
 9. Industry or business in which work was done, as saw mill, bank, etc. Rail Road
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 14

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clinton Mo

13. NAME Noah Cloe

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Logansport Ind

15. MAIDEN NAME Mattie Blanchard

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Green Co Mo

17. INFORMANT (ADDRESS) Hattie Cloe Clinton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Sebo DATE 5-21 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred Wilkerson Clinton Mo

20. FILED 5 21 39 J. R. Hampton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-19 39

22. I HEREBY CERTIFY, That I attended deceased from 4-7 39 to 5-13 39
 I last saw him alive on 4-26 39 Death is said to have occurred on the date stated above, at 430 P.M.
 The principal cause of death and related causes of importance were as follows:
Mycarditis
Paralysis
 Date of onset 7

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? To

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) James O. Smith, M. D.
 (Address) Clinton Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1-10003

JAN 25 1948

RECEIVED
District Health Officer No. 7,
District File Number 7-39-90
Date Filed 6-6-39

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Fred Wilkerson
Licensed Embalmer No. 2478
P. O. Address Clinton mo

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 this body is not embalmed, above space should be left blank..