

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 475

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Mo. Methodist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
In this community 37 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1802 Francis  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN HENRY CLEVELAND

3. (b) If veteran, name war none  
3. (c) Social Security No. 491-09-8589

4. Sex male 5. Color or race White  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Minnie L. Cleveland  
6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased February 22 1879  
(Month) (Day) (Year)

8. AGE: Years 65 Months 2 Days 11  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Danville Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation supertendent  
11. Industry or business St. Joseph Tent & Awning Co.

12. Name Henry Cleveland  
13. Birthplace unknown Penn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Jane Keller  
15. Birthplace unknown Penn.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. H. Cleveland  
(b) Address 1302 Francis  
17. (a) burial (b) Date thereof 5/8/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park  
18. (a) Signature of funeral director Heaton Bube & Bowman  
(b) Address 319 South 10th

19. (a) 5/5/44 (b) Mrs. Helen J. Palko  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3  
year 1944 hour 10 minute 10P M.

21. I hereby certify that I attended the deceased from Aug 17 1939 to May 3 1944  
that I last saw him alive on May 3 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Lympho sarcoma  
Due to Radiocemi-teril - kept in  
in abeyance for 6 2/3 yrs  
Due to ly x ray treatment

Duration 1937

Other conditions (Include pregnancy within 3 months of death)

Major findings: Diagnosed Sept 1937  
Lympho sarcoma  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature S. P. Senor M.D. (M. D. or other) \_\_\_\_\_  
Address St. Joseph Mo Date signed 5-4-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

11  
1  
7

Mr. L E Senior  
722 1/2 Francis

**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 Frank A. Downing

Licensed Embalmer No. 1710

P. O. Address St Joseph 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, fact should be so stated above.