. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21503

Registration District No. 336 Primary Registration District No. 6125 Registrar's No.

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Summersville Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No. Carts Twp 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No. (Specify whether
In this community 26 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Shannon 101
(c) City or town Summersville Mo (If outside city or town limits, write "RURAL")
(d) Street No. Rural Carts Twp (If rural, give location)
(e) Citizen of foreign country? No. 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah E Cleaver
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife F M Cleaver
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Nov 28 1861 (Month) (Day) (Year)

8. AGE: Years 82 | Months 6 | Days 29 | If less than one day ___ hr. ___ min.

9. Birthplace (City, town, or county) Tenn. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name George Birdwell
13. Birthplace (City, town, or county) Tenn (State or foreign country)
MOTHER
14. Maiden name Nancy A Houston
15. Birthplace (City, town, or county) Tenn (State or foreign country)
16. (a) Informant F M Cleaver
(b) Address Summersville Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28-45 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Side Cem.
18. (a) Signature of funeral director John F Duncan
(b) Address Mtn View Mo
19. (a) 7-10-45 (Date received local registrar) (b) Frank Boyd MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27th year 1945 hour 1 minute 20 a.M.
21. I hereby certify that I attended the deceased from Mar 2 1945, to June 26, 1945 that I last saw her alive on June 27, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis
Due to
Due to Interstitial Nephritis
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Dr Lavere Hampton (M. D. or other) D.O
Address Summersville Date signed June 30

744 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5.
District File Number 745334
Date Filed 7/12/45

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.

Not Embalmed

Signed John J. Duncan

Licensed Embalmer No. 2516

P. O. Address Mtn View 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.