S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 29 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40343

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 43

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Grim-Smith Hospital & Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 37 days (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Sullivan
(c) City or town: Winnigan
(If outside city or town limits, write "RURAL")
(d) Street No. — (If rural, give location) /
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME: ~~Bertha Augusta Cleeton~~ Mrs. James M. Cleeton

3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex: female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: James Cleeton
6. (c) Age of husband or wife if alive: 59 years
7. Birth date of deceased: January (Month) 3 (Day) 1880 (Year)

8. AGE: Years 65 Months 9 Days 28 If less than one day hr. min.

9. Birthplace: Sullivan Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
MOTHER FATHER
12. Name: August Gustaval Sorge
13. Birthplace: Germany (City, town, or county) (State or foreign country)
14. Maiden name: Mary Frances Harrell
15. Birthplace: Mo. (City, town, or county) (State or foreign country)
16. (a) Informant: James M. Cleeton
(b) Address: Winnigan Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Price Cemetery
18. (a) Signature of funeral director: Henry E. Rust & Son
(b) Address: Green City Mo.
19. (a) 11-5-45 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 31st year 1945 hour 1 minute 25 A.M.

21. I hereby certify that I attended the deceased from September 24, 1945 to October 31, 1945 that I last saw her alive on October 31, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	1 mo.
Due to: Nephritis, chronic	unknown
Due to: 0	
Other conditions: 0 (Include pregnancy within 3 months of death)	
Major findings: Of operations: 0	
Of autopsy: 0	

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: J. Kimp (M. D. or other) M.D.
Address: Kirksville, Mo. Date signed 31 Oct 45

(Licensed Embalmer's Statement on Reverse Side)

NOV 5 1954

RECEIVED
District Health Officer No. 10
District File Number 13-45-1859
Date Filed DEC 20 1945

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.