

FILED SEP 15 1947

State File No. \_\_\_\_\_

Registration District No. 28

Primary Registration District No. 2000

Registrar's No. 763

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Springfield Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 30 hours  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay  
(c) City or town N. Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route 5  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Thomas Hayes Cloud

3. (b) If veteran,

name war Infant

3. (c) Social Security

No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married Infant  
0 divorced Infant  
6. (b) Name of husband or wife Infant  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: August 28, 1917  
(Month) (Day) (Year)

20. DATE OF DEATH: Month August day 28  
year 1947 hour 2:30 minute A. M.

21. I hereby certify that I attended the deceased from 8/28 1947 to Aug 29 1947  
that I last saw him alive on Aug 29 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia with aspiration of fluids in lung  
Due to during fall

Duration

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
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 0 ✓

23. Signature E. J. Feller (M. D. or other)  
Address Springfield Mo Date signed 9/2/47

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

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Paul H. Cloud  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Betty Anderson  
15. Birthplace Kansas City Kansas  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Betty Cloud  
(b) Address Kansas City, Missouri  
17. (a) Burial (b) Date thereof 9-30-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenwood Cemetery  
18. (a) Signature of funeral director Gorman-Scharpf Funeral  
(b) Address Springfield, Missouri Home  
19. (a) 8-30-47 (b) W. E. Handley  
(Date received local registrar) (Registrar's signature)

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**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 L. Edwin Gorman  
Licensed Embalmer No. 3177  
P. O. Address Springfield 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.**