

FILED FEB 17 1947

Registration District No. 19-00 R 7

Primary Registration District No. 5-704 3040

Registrar's No. # 9

1. PLACE OF DEATH:

(a) County Linington  
(b) City or town Claticton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 3 yrs. (months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linington  
(c) City or town Wheeling  
(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 Minnie B. Cleveland

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced wid. 7  
7. Birth date of deceased Feb. 27, 1868  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 11 6 - hr. - min.

9. Birthplace Missouri Co. no. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name George Scott 9  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Paula Ungling  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rosie Woody  
(b) Address Wheeling, Mo.

17. (a) Burial (b) Date thereof 2/5/47  
(Burial, cremation, or removal) (Month) (Days) (Year)  
(c) Place: burial or cremation Wheeling, Mo.

18. (a) Signature of funeral director Donald Jordan  
(b) Address Claticton, Mo.

19. (a) 2/4/47 (b) Mrs. Berta Boone  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3  
year 1947 hour 12 minute 40 P.M.

21. I hereby certify that I attended the deceased from Sept  
1943, to Feb 3, 1947;  
that I last saw her alive on Feb 3, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
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) (c) Means of injury \_\_\_\_\_

23. Signature A. B. Bryan or other \_\_\_\_\_  
Address Wheeling, Mo. Date signed 2/5/47

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

MOTHER FATHER

HEALTH OFFICE  
Cameron, Mo.

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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..... *Donald F. Gordon* .....

Licensed Embalmer No. *491* .....

P. O. Address. *Chillicothe 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28289**

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **491**

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town Wheeling, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Minnie B. Cleveland

3. (b) If veteran,  
name war \_\_\_\_\_

3. (c) Social Security  
No. \_\_\_\_\_

4. Sex \_\_\_\_\_

5. Color or  
race \_\_\_\_\_

6. (a) Single, widowed, married,  
divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_

(b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_

(b) \_\_\_\_\_

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town Wheeling  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 3 day  
year 194 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
\_\_\_\_\_

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

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 \_\_\_\_\_

23. Signature A. A. Bryan (M.D. or other) MD  
Address Wheeling, Mo. Date signed 3/4/47

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

MOTHER FATHER

SUPPLEMENTARY

S-28289

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**