

U.S. No. 300
FORM - 10-47
Rev. 5-17-39
I 3906

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED DEC 23 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 41359

Registrar's No. 10679

1. PLACE OF DEATH:

(a) County.....
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
(Specify whether years, months or days)
In this community.....

3. (a) PRINT FULL NAME Ernest Cloninger

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

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sue 6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased June 19 1912
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 5 19 hr. min.

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

10. Usual occupation Mech. Eng.

11. Industry or business.....

12. Name Joseph Cloninger

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Cora Payne

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Sue Cloninger

(b) Address 7803 Genesta

17. (a) Burial (b) Date thereof 12/11/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lakewood Park Cemetery

18. (a) Signature of funeral director J. L. Ziegenhein & Sons

(b) Address 7027 Gravois Ave.

19. (a) DEC 10 1948 (b) J. B. Lancaster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis
(c) City or town Lakewood
(If outside city or town limits, write "RURAL")
(d) Street No. 7803 Genesta
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 8
year 1948 hour 3 minute PM

21. I hereby certify that I attended the deceased from Oct 27, 1948, to Dec 8, 1948;
that I last saw him alive on Dec 7, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration was

Due to chronic glomerulo nephritis Known

Due to.....

Other conditions (Include pregnancy within 3 months of death) 1/2/6

Major findings: Of operations.....
Of autopsy no report as yet

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 Robert M. Smith (M. D. or other) MD
Address 114 N. Taylor Date signed 12/9/48

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

MOTHER FATHER

MAR 26 1958

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 Francis J. Owens

Licensed Embalmer No. 2245

P. O. Address St. Louis - 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.