

29324

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 3- 1952

 BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7677**

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Texas b. COUNTY Colorado | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 0 | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sheridan 8 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hospital | | d. STREET ADDRESS (If rural, give location) Box 671 | |

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|---|-------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) Earl b. (Middle) Cloninger c. (Last) Cloninger | | | 4. DATE OF DEATH (Month) (Day) (Year) Aug. 12, 1952 | | |
| 5. SEX Male <input checked="" type="checkbox"/> | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH May 3, 1906 | | 9. AGE (In years last birthday) 46 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Rice | | 11. BIRTHPLACE (State or foreign country) Comanche, Okla. / | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |

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|--|--|---|--|--|--|
| 13a. FATHER'S NAME Otis Cloninger | | 13b. MOTHER'S MAIDEN NAME Janette Harrison | | 14. NAME OF HUSBAND OR WIFE Vivian Turner Cloninger | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Vivian Cloninger, Sheridan, Texas | |

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized metastases of Carcinoma of the Parotid. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Carcinoma of Right Parotid Gland II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 1 yr. | |
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|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION Carcinoma of Parotid Gland, left right | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 1421 | |

22. I hereby certify that I attended the deceased from **Aug 10, 1952**, to **Aug 12, 1952**, that I last saw the deceased alive on **Aug 12, 1952**, and that death occurred at **3:20 a.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE [Signature] (Degree or title) MD | | 23b. ADDRESS 16 Hampton Village Way | | 23c. DATE SIGNED 8-12 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE Aug. 12, 1952 | | 24c. NAME OF CEMETERY OR CREMATORY | |
| 24d. LOCATION (City, town, or county) Columbus, Texas | | 24e. (State) | | | |

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|---|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. AUG 12 1952 | | REGISTRAR'S SIGNATURE [Signature] | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Weick Bros. 2201 So. Grand Blvd. | |
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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.