

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 31 1953

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State File No. 26220  
Registrar's No. 6383

|  |  |  |                           |   |  |  |                  |  |         |  |
|--|--|--|---------------------------|---|--|--|------------------|--|---------|--|
| BIRTH NO. _____  |  | REG. DIST. NO. _____   |                           | PRIMARY REG. DIST. NO. _____  |  | Registrar's No. _____  |                  |  |         |  |
| 1. PLACE OF DEATH<br>a. COUNTY   |  |  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE   |  |  |                  | b. COUNTY  |         |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN)  |  |  |                           | c. CITY OR TOWN   |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |                  |  |         |  |
| c. LENGTH OF STAY (in this place)  |  |  |                           | e. STREET ADDRESS (If rural, give location)   |  | 1109   |                  |  |         |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION  |  |  |                           | 5861 Cates Ave.   |  |  |                  |  |         |  |
| 3. NAME OF DECEASED (Type or Print)  |  |  | a. (First)                |   |  | b. (Middle)  |                  |  |         |  |
| Bertie   |  |  | Elizabeth                 |   |  | c. (Last)  |                  |  |         |  |
| Cloonan  |  |  | 4. DATE OF DEATH          |   |  | (Month) (Day) (Year)   |                  |  |         |  |
| June   |  |  | 24,                       |   |  | 1953   |                  |  |         |  |
| 5. SEX   |  | 6. COLOR OR RACE   |                           | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)  |  | 8. DATE OF BIRTH   |                  | 9. AGE (In years last birthday)  |         |  |
| Female   |  | White  |                           | Widow   |  | April 2, 1880  |                  | 73   |         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and State or Foreign Country)   |                  | 12. CITIZEN OF WHAT COUNTRY?   |         |  |
| Merchant   |  |  |                           | 5-10 Store  |  | Ruble, Mo.   |                  | U.S.   |         |  |
| 13a. FATHER'S NAME   |  |  | 13b. MOTHER'S MAIDEN NAME |   |  | 14. NAME OF HUSBAND OR WIFE  |                  |  |         |  |
| William Vineyard   |  |  | Elizabeth Hampton         |   |  | Martin   |                  |  |         |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)  |  |  | 16. SOCIAL SECURITY NO.   |   |  | 17. INFORMANT'S SIGNATURE OR NAME  |                  |  | ADDRESS |  |
| No   |  |  |                           |   |  | L.M. Hackworth, Ruble, Mo.   |                  |  |         |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  |  |                           | MEDICAL CERTIFICATION   |  |  |                  | INTERVAL BETWEEN ONSET AND DEATH   |         |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)   |  |  |                           | Cerebral hemorrhage   |  |  |                  | 7 days   |         |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.   |  |  |                           | II. OTHER SIGNIFICANT CONDITIONS  |  |  |                  |  |         |  |
| Antecedent Causes  |  |  |                           | Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. |  |  |                  | 3 yrs  |         |  |
| DUE TO (b)   |  |  |                           | Gail arteriosclerosis   |  |  |                  |  |         |  |
| DUE TO (c)   |  |  |                           |   |  |  |                  |  |         |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |                           |   |  |  |                  | 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) (Min.)   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                           | 21f. HOW DID INJURY OCCUR?  |  |  |                  |  |         |  |
|  |  |  |                           | 33ix  |  |  |                  |  |         |  |
| 22. I hereby certify that I attended the deceased from Jan 1951, to June 24, 1953, that I last saw the deceased alive on June 22, 1953, and that death occurred at 10:36am from the causes and on the date stated above. |  |  |                           |   |  |  |                  |  |         |  |
| 23a. SIGNATURE (Degree or title)   |  |  |                           | 23b. ADDRESS  |  |  | 23c. DATE SIGNED |  |         |  |
| Arthur B. Day M.D.   |  |  |                           | 2720 Washington   |  |  | 6-25-53          |  |         |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24b. DATE  |                           | 24c. NAME OF CEMETERY OR CREMATORY  |  | 24d. LOCATION (City, town, or county) (State)  |                  |  |         |  |
| Removal  |  | 6-24-53  |                           | New Masonic Cemetery  |  | Potosi, Mo.  |                  |  |         |  |
| DATE REC'D BY LOCAL REG.   |  | REGISTRAR'S SIGNATURE  |                           |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |  |                  |  |         |  |
| JUN 26 1953  |  | J. Carl Smith M.D.   |                           |   | Smith Funeral Home, Potosi, Mo.          |  |                  |  |         |  |

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

4419 5 1922

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.....  
Signature of Student Embalmer

Signed..... *G. W. Wilkinson*

Licensed Embalmer No..... *35*

P. O. Address *W. Low*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.