

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

28907

Registration District No. 255 Primary Registration District No. 5877 Registrar's No. 15

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Oregon</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Piney Township</u>		c. CITY OR TOWN <u>Piney Township</u>		d. STREET ADDRESS (If outside, give location)	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <u>49 years</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last <u>Christopher Caleb Cloven</u>				Month Day Year <u>July 5, 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1884</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Greenfield, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Cloven</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ferguson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Brents Cloven, Couch, Missouri</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases: Carcinoma Gastric, &amp; Intestinal</u>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>Mal-nutrition: inability to carry body functions</u>							
DUE TO (c) <u>Aged body changes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
							<u>1998</u>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				
Hour Month, Day, Year a. m. p. m.			20e. CITY, TOWN, OR LOCATION COUNTY STATE <u>Altam Oregon Mo.</u>				
20f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
21. I attended the deceased from <u>7-21-51</u> to <u>7-5-57</u> and last saw <u>him</u> alive on <u>7-4-57</u> Death occurred at <u>11:00</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (In full) <u>[Signature]</u> D.O.				22b. ADDRESS <u>Altam, Mo.</u>		22c. DATE SIGNED <u>8-1-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-7-57</u>		<u>Cave Springs Cemetery</u>		<u>Oregon County, Missouri</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Aug 27/57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs W C Johnson</u>	

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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(Licensed Embalmer's Statement) (On Reverse Side)

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 *J. M. Carter*.....

Licensed Embalmer No. *4*

P. O. Address *Hayes*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.