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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-029606
STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 167 Primary Registration District No. 3040 Registrar's No. 204

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Chillicothe Hosp. — Length of stay in 1b 3 hrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Livingston
c. CITY OR TOWN Chillicothe 05920 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 505½ Locust St. — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First PATRICIA Middle GERTRUDE Last CLEVELAND

4. DATE OF DEATH Month August Day 16 Year 1958

5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH Feb. 4, 1896
9. AGE (In years last birthday) 62 — 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) Practical Nurse
10b. KIND OF BUSINESS OR INDUSTRY Nursing
11. BIRTHPLACE (City and state or country) Pollock, Missouri 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joshua Camp
13b. MOTHER'S MAIDEN NAME Mary Thompson
14. NAME OF HUSBAND OR WIFE Archie Cleveland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) unknown
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs. Mae Olinger; Pollock, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Central Embolism — INTERVAL BETWEEN ONSET AND DEATH 3 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 332 X
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 [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8-16-58, to and last saw her/him alive on 8-16-58
Death occurred at Four Fifteen P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M C Everett D.O. (Degree or title)
22b. ADDRESS Chillicothe
22c. DATE SIGNED 8-18-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Aug. 19, '58
23c. NAME OF CEMETERY OR CREMATORY Green Mounds Cem
23d. LOCATION (City, town, or county) (State) Quincy, Illinois

24. FUNERAL DIRECTOR NORMAN FN'L HOME ADDRESS Chillicothe, Mo.
25. DATE RECD. BY LOCAL REG. Aug 18 '58
26. REGISTRAR'S SIGNATURE Frances B Neill.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

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 Joseph M. Gibson

Licensed Embalmer No 4769

P. O. Address Chillicothe, M

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.