Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035324
STATE FILE NUMBER

FILED OCT 20 1958 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 325

1. PLACE OF DEATH a. COUNTY Adair	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Adair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN 0013 Kirksville — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) K.O.Hospital. — Length of stay in 1b 1 month	d. STREET ADDRESS (If outside, give location) 414 N Florence — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First ARTHUR	Middle G.	Last CLOYD	4. DATE OF DEATH Month Oct. 12 Day Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH Aug.24, 1892	9. AGE (In years last birthday) 66 — 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 Farming(Ret.)		11. BIRTHPLACE (City and state or country) Sangamon Co. Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mathew F. Cloyd			14. MOTHER'S MAIDEN NAME Emma Thayer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ----------		16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs.A.G.Cloyd, Kirksville, Mo.	

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) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 month

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis — years

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 ☒ 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 1956, to Oct 12 1958 and last saw her/him alive on Oct 11

Death occurred at 6 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M T Gutensohn 2 DO	22b. ADDRESS Kirksville Mo	22c. DATE SIGNED 10-12-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-14-1958	23c. NAME OF CEMETERY OR CREMATORY Maple Hills Cemetery	23d. LOCATION (City, town, or county) (State) Kirksville, Mo.
24. FUNERAL DIRECTOR ADDRESS Davis & Davis, Kirksville, Mo.	25. DATE RECD. BY LOCAL REG. 10-17-1958	26. REGISTRAR'S SIGNATURE Doris W. Ratliff	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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OCT 21 19

APR 2 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Robert B. Harris

Licensed Embalmer No. 4319

P. O. Address Kirksville

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