

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035221

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2427

STATE FILE NUMBER

AMENDED

FILED SEP 13 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Posey	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton, Mo.		Length of stay in 1b DOA	c. CITY OR TOWN Mount Vernon Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 631 Main, St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Guy Middle Cleveland Last Cleveland			4. DATE OF DEATH Month August Day 27 Year 1961
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/18/1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired County Clerk		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (last birthday) 74 IF UNDER 1 YEAR Months _____ Days _____
11. BIRTHPLACE (City and state or country) Indiana.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Louis Cleveland		13b. MOTHER'S MAIDEN NAME Elizabeth Meadows	14. NAME OF HUSBAND OR WIFE Mary CLEVELAND
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No.		16. SOCIAL SECURITY NO. Nil.	17. INFORMANT Address Mary Cleveland, 631 Main, St. Mount Vernon, Indiana.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary thrombosis			4200
DUE TO (c) Arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	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 November 19, 1952 , to two or three and last saw her alive on two or three years ago. Death occurred at approx. 2:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated ago.			
22a. SIGNATURE (Degree or title) <i>John B. Hoppe, M.D.</i>		22b. ADDRESS 634 N. Broad	22c. DATE SIGNED 8-28-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-28-61	23c. NAME OF CEMETERY OR CREMATORY _____	23d. LOCATION (City, town, or county) (State) Mount Vernon, Indiana
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. 8/29/61	26. REGISTRAR'S SIGNATURE <i>John B. Hoppe, M.D.</i>

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 Stanley H. Aijon
Licensed Embalmer No. 4193
P. O. Address St. Louis

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.