

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH** *permit # 83-023733*

DEPARTMENT OF PUBLIC HEALTH AND WELFARE *82*

Registration District No. \_\_\_\_\_ Primary Registration District No. *5309* Registrar's No. *89*

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_  
**FILED JUL 8 1963**

VS 300  
Rev. 4/59

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*24000*

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Cooper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Boonville Twp</b>		Length of stay in 1b <b>1 hr.</b>	c. CITY OR TOWN <b>LeMay 25,</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RFD Boonville, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>713 Bella Vista</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>BETTY JUNE CLEVELAND</b>		4. DATE OF DEATH Month Day Year <b>June 29, 1963</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/31</b>
9. AGE (last birthday) <b>32</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor Budget Dept</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Kirby Cleveland</b>	
13b. MOTHER'S MAIDEN NAME <b>Leora Gross</b>		14. NAME OF HUSBAND OR WIFE <b>Kirby Cleveland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <b>no</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Kirby Cleveland</b>		Address <b>713 Bella Vista LeMay, 25, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Body dismembered by violence</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Violence</b>			
DUE TO (c) <b>Auto wreck</b>			
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 checked="" 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) <b>Auto wreck - Body dismembered in 3 sections</b>	
20c. TIME OF INJURY Hour <b>8:45</b> a.m. Month, Day, Year <b>6-29-63</b>	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.) <b>Highway 40 8 miles west of Boonville</b>		20f. CITY, TOWN, OR LOCATION <b>Cooper</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>8:45</b> m on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at <b>8:45</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <b>Dr. DeGraeger MD</b>		22b. ADDRESS <b>Boonville Mo</b>	22c. DATE SIGNED <b>6/29/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>6/30/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>Hoffmeister FH</b>		25. DATE RECD. BY LOCAL REG. <b>6/29/63</b>	26. REGISTRAR'S SIGNATURE <b>Dr. Hooper</b>

USE BLACK INK OR TYPEWRITER RIBBON

JUL 10 1963

**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 Berry W. Haacker

Licensed Embalmer No. 3944

P. O. Address Boonville, Mo

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.