S. No. 2
I—8-43
5-17-39
I X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 11 1945

Registration District No. 21

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3012

State File No. 20128

Registrar's No. 83

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Excelsior Springs Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days (Specify whether)

In this community all Her Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 87

(a) State Missouri (b) County Ray

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 5 miles West 1½ miles North Orrick, Mo
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MONTANA BELLE CLEVENGER

3. (b) If veteran, name war No

3. (c) Social Security No. No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Albert Clevenger

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased March (Month) 27 (Day) 1877 (Year)

8. AGE: Years 68 Months 2 Days 27 If less than one day hr. min.

9. Birthplace Ray Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation House Wife

11. Industry or business —

MOTHER FATHER

12. Name Thomas Turner

13. Birthplace (City, town, or county) Tenn. (State or foreign country)

14. Maiden name Lydia Jane Siegle

15. Birthplace (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant Mrs Elva Dell Mills

(b) Address Orrick, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/45 (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery, Near Orrick, Mo.

18. (a) Signature of funeral director Herbert Hope

(b) Address Excelsior Springs Mo

19. (a) 6-26-45 (Date received local registrar) (b) Mrs Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from June 5, 1945, to June 23, 1945 that I last saw her alive on June 23 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Anuria	2 Wks
Due to Nephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Dr. Burton Dawson (M. D. or Coroner)

Address 101 S. St., Ex. Spgs., Mo. Date signed 6-26-45

1166

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7/9/47

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed: James A. Moles

Licensed Embalmer No. 3296

P. O. Address Ft Springs Ark

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 this body is not embalmed, fact should be so stated above.

S. No. 2B
5M—3-45
I X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jun 83

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 83

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Montana B. Clevenger

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Mar 27 (Month) (Day) (Year)

8. AGE: Years 68 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) MO (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar 23 day

year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , to , 19 ;

that I last saw h alive on , 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address 7-24-45 Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

5-20128