

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

38144

1. PLACE OF DEATH

County Ray Co. Mo
Township Oriskany
City _____ (No. _____)

Registration District No. 743
Primary Registration District No. 5978

File No. _____
Registered No. 31
St. _____ Ward _____

2. FULL NAME

Mary Ellen Cleverger

(a) Residence. No. _____ St. _____ Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Wm. J. Cleverger

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

4-27-1878

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>51</u>	<u>6</u>	<u>28</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ray Co. Mo

PARENTS

10. NAME OF FATHER

Jacob Wickstrom

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Sweden

12. MAIDEN NAME OF MOTHER

Johanna Sorenson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Sweden

14. INFORMANT

Cordelia Cleverger

(Address) Richmond Mo

15. FILED

Nov 16 1929 L. E. Ellis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-15 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1929, to Nov 15, 1929
that I last saw h. alive on Nov 9, 1929, and that death occurred, on the date stated above, at 11:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary Valvular Heart Disease

92A (duration) 2 yrs. mos. da.

CONTRIBUTORY (SECONDARY) 92A (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) L. E. Ellis M. D.

(Address) Oriskany Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Union Cemetery

DATE OF BURIAL

11-17 1929

20. UNDERTAKER

C. Y. Gibson

ADDRESS

Oriskany Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. **PHYSICIANS SIGNATURES** are essential. **DO NOT SIGN UNLESS YOU KNOW DECEASED EXACTLY.**

89

230

24

