No. 2
2-45
17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25113

Registration District No. 2918 Primary Registration District No. 6024 Registrar's No. 13

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Rural Polk
(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 29 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 89
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Minnie Estella 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 widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. (Month) 16 (Day) 1870 (Year)

8. AGE: Years 77 Months 7 Days 25 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Arnate
13. Birthplace (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Marona Beorgan
15. Birthplace (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs. Tom Cates
(b) Address Lawson, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem. Cemetery

18. (a) Signature of funeral director Garman-Crickard
(b) Address Lawson, Mo.

19. (a) July 13 19 47 (Date received by local registrar) (b) Mrs. Raymond Hope (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11th
year 1947 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from August 10 1946 to July 11th 1947
that I last saw her alive on July 11th 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis — Duration sudden
Hypertension, Arteriosclerosis
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
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 0

23. Signature H. W. Crockett (M. D. or other) M. D.
Address Excelsior Springs, Mo. Date signed 7/12/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 8-12-47

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 E. E. White

Licensed Embalmer No. 4468

P. O. Address Excelsior Spgs, 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 this body is not embalmed, fact should be so stated above.

. No. 2B
M—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. Aug

Registration District No. 298 Primary Registration District No. 6024 Registrar's No. 18

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural
(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 Minnie E. 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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov 16 1863
(Month) (Day) (Year)

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name

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

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) Mrs. Raymond Hood (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1947 hour 6 minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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 Date signed

5-25113