

JAN 10 1942

Registration District No. 844

Primary Registration District No. 6107

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Ponce de Leon, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution most all of life
(Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME William Wallace Cloud

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex m. 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ida Cloud 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Jan 3-1873
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 11 If less than one day hr. min.

9. Birthplace Ark. 1 (City, town or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name Buel Cloud
13. Birthplace unknown 9 (City, town, or county) (State or foreign country)
14. Maiden name Sarah Goff
15. Birthplace unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant Oda Cloud
(b) Address Ponce de Leon, Mo.

17. (a) Burial (b) Date thereof Dec. 16-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ponce de Leon Cem.

18. (a) Signature of funeral director T. W. Magers
(b) Address Clever, Mo.

19. (a) 12-30-41 (b) Ola Magers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stone 109
(c) City or town Ponce de Leon 0
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 14th
year 1941 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct. 27
1941, to _____ 19____;

that I last saw him alive on Oct 27-1941 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94a

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M.D. or other) Ths

Address [Address] Date signed 12-26-41

RECEIVED

District Health Officer No. 6,

District File Number 142-33

Date Filed JAN 6 1942

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.....

J. W. Maples

Licensed Embalmer No. 2985

P. O. Address Cheney, 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.