

APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9128
Registrar's No. 2538

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Johns Hospital.
(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 Missouri. (b) County _____
(c) City or town St. Louis.
(If outside city or town limits, write "RURAL") _____
(d) Street No. 1303 Montgomery St.
(If rural, give location) _____
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Robert Cline.
3. (b) If veteran, name war No.
3. (c) Social Security No. None.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 20
year 1941 hour 4 minute 30 A.M.

4. Sex Male. 5. Color or race White.
6. (a) Single, widowed, married, divorced, Single.
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 13 1940.
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 1, 1941, to Feb 20, 1941
that I last saw him alive on Mar 20, 1941
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
3 3 7 hr. _____ min.

Immediate cause of death. Congenital Anomaly of the Brain
Due to _____
Due to _____

9. Birthplace St. Louis, Missouri.
(City, town, or county) (State or foreign country)
10. Usual occupation Child.
11. Industry or business _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER { 12. Name William Cline.
13. Birthplace Missouri.
(City, town, or county) (State or foreign country)
14. Maiden name Opal Pace.
15. Birthplace Missouri.
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Opal Cline.
(b) Address 1303 Montgomery St.
17. (a) Burial (b) Date thereof 3-22-41.
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Friedens Cem.
18. (a) Signature of funeral director Hy. Leidner Und. Co.
(b) Address 2223 St. Louis Ave.
19. (a) MAR 21 1941 (b) J. H. Bredeek
(Registrar's signature)

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 P. J. Mannon (M. D. or other) _____
Address 4902^a Menden Date signed Mar 20-41

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

No. 2
-13-40
-17-39
I X23159

Ch. 1454

Dr. P. J. Morrison
Mrs. Weaver 6-9999
11-1 P.M.
Jan 3-4 83

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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St Louis av

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.