

FILLED NOV 14 1941

Registration District No. _____

Primary Registration District No. 1001

Registrar's No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph, Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. Hospital 2 Weeks
In this community 5 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 913 Mitchell Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Josephine Cline

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Norman G. Cline 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased October 20 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 11 17 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name John Workman
13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Jennings
15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Norman G. Cline

(b) Address 913 Mitchell Ave. St. Joseph, Mo.

17. (a) Burial (b) Date thereof 10/21/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Whitesville, Missouri

18. (a) Signature of funeral director Halter Meierhoffer

(b) Address 1302 Faraon St., St. Joseph, Mo.

19. (a) Oct 20, 1941 (b) J. Westphal
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 17
year 1941 hour 2 minute 35 A. M.

21. I hereby certify that I attended the deceased from 9-30, 1941 to 10-17, 1941
that I last saw her alive on 10-17, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Multiple lung infarcts
Chronic cystitis
Myocardial fibrilosis
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 111a
Of autopsy See above

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 W. W. Stacey (M. D. or other) MD
Address St. Joseph, Mo. Date signed 10/21/41

Duration
Underline the cause to which death should be charged statistically.

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

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.....

Oby J. Ester

Licensed Embalmer No..... Mo. #4154

P. O. Address..... St. Joseph, Missouri

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.