

FILED MAR 22 1948

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 322

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph 5
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mercy Hospital 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Day (Specify whether
 In this community 50 Yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Buchanan //
 (c) City or town Rural St. Joseph 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. Route 5 0
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Lewis Madison Cline
 3. (b) If veteran, name war No 3. (c) Social Security No. none

4. Sex Male 0 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Frances Elizabeth
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 16 1865
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>82</u>	<u>9</u>	<u>22</u>	hr. min.

9. Birthplace Megosa Co. Ohio
 (City, town, or county) (State or foreign country)
 10. Usual occupation Retired
 11. Industry or business _____

MOTHER FATHER
 { 12. Name Unknown 7
 13. Birthplace Unknown 7
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown 9
 15. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Jennie May McDowell
 (b) Address R. R. #5 St. Joseph, Mo.
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 6, 1948
 (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Auburn Cem.
 18. (a) Signature of funeral director Earl A. Clark
 (b) Address 120 Illinois Ave. St. Joseph, Mo.
 19. (a) 3-16-48 (Date received local registrar) (b) C. G. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 4th
 year 1948 hour 6 minute 30 PM
 21. I hereby certify that I attended the deceased from
3-3, 1948, to 3-4, 1948
 that I last saw him alive on 3-4, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage Duration 2 days
 Due to Arterio sclerosis ?
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: BP
 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 Earl A. Clark (M. D. or other) DO.
 Address 5008 Spring Hill Ave Date signed 3-5-48

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 *Emma Clark*.....

Licensed Embalmer No. *4238*.....

P. O. Address *St. Joseph 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.