

No. 300
10.48

FILED APR 5 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10791
28

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wash Township</u>	c. LENGTH OF STAY (In this place) <u>16 1/2</u>	c. CITY OR TOWN <u>Maneas</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hosp 3 Nevada Mo</u>		e. STREET ADDRESS (If rural, give location) <u>rural</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>HOMER</u>	b. (Middle) <u>-</u>	c. (Last) <u>CLINE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 29, 1955</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>Jan 1888</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>3</u>	IF UNDER 12 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Maneas Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		

13a. FATHER'S NAME <u>William Cline</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Canon</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hosp 3 Nevada Mo</u>	ADDRESS <u>331X</u>
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18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month & 7 days</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) <u>Hypertension and</u>		
	DUE TO (c) <u>arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>Psychosis & mental deficiency</u>		

19a. DATE OF OPERATION <u>no</u>	19b. MAJOR FINDINGS OF OPERATION <u>no</u>	20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331X</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1939, to March 29, 1955, that I last saw the deceased alive on March 29, 1955, and that death occurred at 6:05 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Paul L. Barone M.D.</u>	23b. ADDRESS <u>State Hosp 3 Nevada Mo</u>	23c. DATE SIGNED <u>March 29/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Remove</u>	24b. DATE <u>3/28/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	24d. LOCATION (City, town, or county) (State) <u>Mountain Grove, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>3-31-'55</u>	REGISTRAR'S SIGNATURE <u>Arma & Ferry</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>R. W. Barber, Mt. Grove, Mo.</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

1080

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Levin J. Lusk*

Licensed Embalmer No. *48*

P. O. Address *Meriden*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.