

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36728**

FILED NOV 9 - 1956

BIRTH NO. _____ REG. DIST. NO. **328** PRIMARY REG. DIST. NO. **4492** Registrar's No. **42**

1. PLACE OF DEATH a. COUNTY SCOTT SCOTT		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission). a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ORAN		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ORAN	
c. LENGTH OF STAY (in this place) 43YRS		d. STREET ADDRESS (If rural, give location) ORAN	
d. FULL NAME OF HOSPITAL OR INSTITUTION ORAN			

3. NAME OF DECEASED (Type or Print)	a. (First) JESSE	b. (Middle) ANDERSON	c. (Last) CLINE	4. DATE OF DEATH (Month) (Day) (Year) OCT. 29 1956
-------------------------------------	-------------------------	-----------------------------	------------------------	---

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 16 1881	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 Hrs. Hours	IF UNDER 1 Mins. Mins.
--------------------	-------------------------------	---	--------------------------------------	---	------------------------	----------------------	-----------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOCTOR	10b. KIND OF BUSINESS OR INDUSTRY MEDICAL	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	--	---	--

13a. FATHER'S NAME NELSON CLINE	13b. MOTHER'S MAIDEN NAME ELIZABETH McGEE	14. NAME OF HUSBAND OR WIFE FLOY CLINE
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME FLOY CLINE	ADDRESS ORAN, MO.
--	----------------------------------	---	--------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure		Sudden
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis DUE TO (c) Senility		10 yr.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility			4222-

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Sudden death from unknown natural diseases	20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO
------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **Nov. 19**, 19____, to _____, 19____, that I last saw the deceased alive on **Oct. 25**, 19**56**, and that death occurred at **10:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE W. O. Finney, M.D.	(Degree or title)	23b. ADDRESS 342 Bldg. Chaffee, Mo.	23c. DATE SIGNED 11/1/56
--	-------------------	--	---------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	24b. DATE NOV. 3 1956	24c. NAME OF CEMETERY OR CREMATORY FOREST HILLS MEMORIAL	24d. LOCATION (City, town, or county) (State) MORLEY MO.
--	------------------------------	---	---

DATE REC'D BY LOCAL REG. 11-3-56	REGISTRAR'S SIGNATURE Mrs. Fred B. ...	25. FUNERAL DIRECTOR'S SIGNATURE Carl J. Smith	ADDRESS ORAN, MO.
---	---	---	--------------------------

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

DATE RECEIVED NOV 5 1956

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1156-228

NOV 5 1956

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Earl J. Smith

Signed.....
Student Embalmer

Licensed Embalmer No. 2676

P. O. Address Orean, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

.If this body is not embalmed, fact should be so stated above.