

FILED DEC 2 - 1957

STANDARD CERTIFICATE OF DEATH

41845
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11082

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Sikeston Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Length of stay in lb 5 days	d. STREET ADDRESS (If outside, give location) Route 2 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Cline			4. DATE OF DEATH Month November Day 19 Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Operator		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 58 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11a. FATHER'S NAME William Henry Cline		11b. MOTHER'S MAIDEN NAME Lena Kline	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME William Henry Cline		14. NAME OF HUSBAND OR WIFE Susie 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. Unknown	17. INFORMANT Address Susie Cline, Rt. 2 - Sikeston, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism; Bronchial Asthma; Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Atelectasis; DUE TO (c) Fracture of Right Illium.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Enter only one condition per line for (a), (b), and (c).) None			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in PART I or PART II of item 18) suffered in auto accident near Sikeston, Mo. about Nov 12 1957		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 27	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION Sikeston, Mo.	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 540 R. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James M. Kelly (Deputy Registrar)		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 11-19-57		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-19-57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) Sikeston, Mo.
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. NOV 19 57	
REGISTRAR'S SIGNATURE Carl Smith MD			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

X St. Louis St. Louis
 X St. Luke's Hospital 2 days
 Route 2
 Cline
 March 7, 1928
 Lockhouse, Mo.
 State Cline
 State Cline, Mt. S. - Sikeston, Mo.
 U.S.
 1927, 19, 1257
 1561
 8
 28

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 Elton R. Remelius

Licensed Embalmer No. 4283
 P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
 If this body is not embalmed, fact should be so stated above.