

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004328

STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

FILED FEB 24 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 57

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Iowa</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Mt. Sterling</b> <b>9140</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Laughlin Hosp.</b>		Length of stay in 1b <b>1 wk.</b>	d. STREET ADDRESS <b>RFD</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Carl B. Cline</b>			4. DATE OF DEATH Month Day Year <b>2/14/59</b>	
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/26/1903</b>	9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR Month Day <b>10 12</b>	IF UNDER 24 HRS. Hours Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Granger, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Thad T. Cline</b>	13b. MOTHER'S MAIDEN NAME <b>Flora Belle Colstadt</b>	14. NAME OF DECEASED'S WIFE <b>Opal Cline</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>481-46-2481</b>	17. INFORMANT Address <b>Mrs. Carl Cline-Mt. Sterling, Ia</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Monocytic Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Malnutrition</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from **2/12/59** to **2/14/59** and last saw him alive on **2/13/59**  
Death occurred at **6:30am** **2/14/59** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>R. P. Valuck D.O.</b>	22b. ADDRESS <b>Laughlin Hospital</b>	22c. DATE SIGNED <b>2/14/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>2/14/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Granger Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Granger, Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Gerth &amp; Basket-Memphis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2-17-1959</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Ratliff</b>
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All diseases in Part I must be causally related.  
 If any disease is caused by gun, dip, or gas, it should be written in black ink or ribbon type if possible.  
 R. P. VALUCK D.O.  
 MEDICAL CERTIFICATION

MAR 10 1958

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 *Robert B. Harris* .....

Licensed Embalmer No. *4219* .....  
P. O. Address *Kingsville, N* .....

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.