

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031263

FILED VS AUG 18 1959

STATE FILE NUMBER

Registration District No. 380 Primary Registration District No. 3076 Registrar's No. 174

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cedar</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Length of stay in 1b <u>3 Mo.</u>		c. CITY OR TOWN <u>El Dorado Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF DECEASED (If in hospital, give location) HOSPITAL OR INSTITUTION <u>#402 North Cedar St. Jones Nursing Home</u>				d. STREET ADDRESS (If outside, give location) <u>104 S. Park</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>B.</u> Last <u>Cline</u>				4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-85</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Collins, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Louis E. Rainey</u>			13b. MOTHER'S MAIDEN NAME <u>Mary L. Higgins</u>			14. NAME OF HUSBAND OR WIFE <u>Arthur O. Cline</u>	
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.		17. INFORMANT Address <u>Norman Cline, Kansas City, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Stroke</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 half hour</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)			
20c. TIME OF INJURY Hour <u> </u> s.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u>					
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from <u>March 20, 1959</u> to <u>August 4, 1959</u> and last saw ^{her} him alive on <u>August 2, 1959</u> Death occurred at <u>Jones Nursing Home</u> <u>4 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>L. P. McCann</u> (Degree or title) <u>L. P. McCann, M.D.</u>				22b. ADDRESS <u>Moore Building Nevada, Missouri</u>		22c. DATE SIGNED <u>8/10/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-6-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>El Dorado Springs Cen.</u>		23d. LOCATION (City, town, or county) (State) <u>El Dorado Springs, Mo.</u>		
24. FUNERAL DIRECTOR <u>Gwinn-Crothers, El Dorado Springs, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8-11-1959</u>		26. REGISTRAR'S SIGNATURE <u>Anna E. Jurey</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wayl E. Crothers

Licensed Embalmer No. 4419

P. O. Address Edwards Sp

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.