

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033622

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 27 Primary Registration District No. 4035 Registrar's No. 192

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 9 1962

1. PLACE OF DEATH a. COUNTY <u>Bates</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Bates</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rockville</u>		Length of stay in lb <u>35 years</u>	c. CITY OR TOWN <u>Rockville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Cline</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>May-24-1880</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Virgil City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		

13a. FATHER'S NAME <u>John Cline</u>		13b. MOTHER'S MAIDEN NAME <u>Polly A. Beasley</u>		14. NAME OF HUSBAND OR WIFE <u>Nellie May 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. <u>None</u>		17. INFORMANT <u>Nellie May Cline, Rockville, Mo.</u> Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 6 mo.

DUE TO (b) LEFT VENTRICULAR FAILURE 3 yrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____

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 type="checkbox"/> No <input type="checkbox"/> Unknown		
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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 _____ a.m. _____ p.m. Month, Day, Year _____					

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>JUNE 5, 1954</u> to <u>OCT. 4, 1962</u> and last saw him alive on <u>OCT. 4, 1962</u> Death occurred at <u>3:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>M. O. Bjerke, P.O.</u> (Degree title)		22b. ADDRESS <u>Rockville</u>		22c. DATE SIGNED <u>10/5/62</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct-6-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	23d. LOCATION (City, town, or county) <u>Rockville Mo.</u>
24. FUNERAL DIRECTOR <u>Melvin L. JANSSENS, El Dorado Springs Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-6-62</u>	26. REGISTRAR'S SIGNATURE <u>Norman Jean Wilson</u>

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON.

NOV 20 1962

OPD
11/20/62

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 Melvin L. Janssen
Licensed Embalmer No. 4529

P. O. Address El Dorado Spgs.

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.