

MAY 15 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

B. H. 15435

1. PLACE OF DEATH

County Jackson
Township New
City K. C. Mo (No. 2025 Prospect Ave)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1981
St. _____ Ward _____

2. FULL NAME

Anna C. Cline
(a) Residence, No. 2025 Prospect St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Cline

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept-16-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
30 68 7 9

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri13. NAME Wm Dennison14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

15. MAIDEN NAME " "

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "

17. INFORMANT (ADDRESS) John W. Dennis
2025 Prospect, Ave18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE April-27-193719. UNDERTAKER (ADDRESS) Mrs. C. L. Carter
918 Broadway Ave20. FILED 4-27-37 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April-25-1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____

I last saw him _____ alive on _____, 19____ Death is said

to have occurred on the date stated above, at 7: AM

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Date of onset _____Other contributory causes of importance: WName of operation Autopsy Date _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external cause (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) [Signature] M. D.(Address) [Signature]

_____ !

OCCUPATION
MOTHER
FATHER1
31
31

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

