

REC'D SEP 20 1939

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

29352

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 400
(b) Township Praine Primary Registration District No. 6553B Registered No. 154
(c) City _____ (d) Street No. Jackson County, 2000 1/2 S. 1st St. & 1st St.
(e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number) (If of foreign birth? yrs. mos. ds.)

2. PRINT FULL NAME John L. Cline

(a) Residence, No. Jackson County, Home St. _____ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan-8-1863
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 76 5 25
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
9. Industry or business in which work was done, as 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) Iowa (STATE OR COUNTRY) _____13. NAME Unknown14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) _____15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) _____17. INFORMANT Ernest Jackson (ADDRESS) 20 County Home18. BURIAL, CREMATION, OR REMOVAL PLACE K. B. Co. of St. Joseph DATE July 5, 193919. FUNERAL DIRECTOR (NAME) K. B. Co. (ADDRESS) K. B. Co.20. FILED 8/11/39 1939 John L. Cline Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jul 3, 193922. I HEREBY CERTIFY That, I attended deceased from 6-1-39 to 7-3-39I last saw him alive on 7-1-39, 1939. Death is said to have occurred on the date stated above, at 5 a. m.The principal cause of death and related causes of importance were as follows: chron myocarditis

Date of onset _____

Other contributory causes of importance: 93C

Name of operation _____ Date of _____

What test confirmed diagnosis? clinical Was there an autopsy? no23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 1939

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? no If so, specify _____(Signed) J. W. Green, M. D.(Address) Superior, Iowa

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.