

FIELD NOV 14 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

34378

Registration District No.

85

Primary Registration District No.

1001

Registrar's No.

1005

1. PLACE OF DEATH:

(a) County BUCHANAN  
(b) City or town ST. JOSEPH City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: MO. METHO. HOSPITAL (1)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 hrs.  
In this community 4 hrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Marian Cline

3. (b) If veteran, name war - 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race W  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased 10-18-41  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 0 8 hr. min.

9. Birthplace Gallatin Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

MOTHER FATHER { 12. Name William Donald Cline  
13. Birthplace St. Joseph, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Viola Marian Harvey  
15. Birthplace Warland, Ia.  
(City, town, or county) (State or foreign country)

16. (a) Informant William Donald Cline  
(b) Address Gallatin Mo.

17. (a) Removal (b) Date thereof 10-20-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Whiteville, Mo.

18. (a) Signature of funeral director W. D. Cline (Father)  
(b) Address Gallatin Mo.

19. (a) Oct 20 1941 (b) W. D. Nestlebusch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Daviess  
(c) City or town Gallatin  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17 year 41 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct. 17 (4 hrs.) duration, 1941, to Oct. 18, 1941; that I last saw her alive on Oct. 18, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Phrenature 7 mos. Immation  
Due to \_\_\_\_\_

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death) 59

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy no

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. D. Cline (M. D. or other) MD  
Address St. Joseph Mo Date signed 10-19-41

Duration 8 hrs.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

---

---

**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.**