

No. 2
M-2-43
5-17-36
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31771

State File No. _____

Registration District No. 154

Primary Registration District No. 5575

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Grandview (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wychoff Clinic (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year (Specify whether years, months or days) 3 years

3. (a) PRINT FULL NAME Rodney Leroy Cline

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced —

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 8 1940
(Month) (Day) (Year)

8. AGE: Years 3 Months 3 Days 18 If less than one day hr. min.

9. Birthplace Kansas City, MO. (City, town, or county) (State or foreign country)

10. Usual occupation child

11. Industry or business _____

MOTHER FATHER { 12. Name Jeff Cline

13. Birthplace Hodge, MO. (City, town, or county) (State or foreign country)

14. Maiden name Wendy Joseph

15. Birthplace Kansas City, MO. (City, town, or county) (State or foreign country)

16. (a) Informant Jeff Cline

(b) Address 434 Blue Ridge

17. (a) Burial (b) Date thereof 8/28/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hills

18. (a) Signature of funeral director George E. Carson
(b) Address Independence, MO.

19. (a) 8-28-43 (b) Dr. Annie H. Hedges
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(d) Street No. 434 Blue Ridge (If rural, give location) #3
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Aug day 26 year 1943 hour 8:15 a. M.

21. I hereby certify that I attended the deceased from Graves 19____ that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Death by electrocution Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1939

Major findings: Of operations _____

Of autopsy See above

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) gun accident 048

(b) Date of occurrence 8/26/43

(c) Where did injury occur? Indian Co. Wv. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? no (Specify type of place) Child took hold of light
(e) Means of injury bullet

23. Signature Dr. Annie H. Hedges (M. D. or other) _____ Date signed 8/28/43

Address Ken _____

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

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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..... *Frank Be...*

Licensed Embalmer No. *2767*

P. O. Address *Indep. Mo.*

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, fact should be so stated above.