

FILED MAY 15 1944

Registration District No. 158

Primary Registration District No. 3127

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1215 N. Nelson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 27 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Webb City
(If outside city or town limits, write "RURAL")
(d) Street No. 1215 N. Nelson
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Henry M. Cline

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Otta Cline 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 5 1865
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 16 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Henry Cline
13. Birthplace No data (City, town, or county) (State or foreign country)
14. Maiden name No data
15. Birthplace No data (City, town, or county) (State or foreign country)

16. (a) Informant Widow Otta Cline

(b) Address 1215 N. Nelson
17. (a) burial (b) Date thereof 4/24/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Delaware Memorial

18. (a) Signature of funeral director Hedge Nelson

(b) Address Webb City, Mo

19. (a) Apr. 24 1944 (Date received local registrar) Mrs. F. L. Lyle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21
year 1944 hour 4 minute 15 M.

21. I hereby certify that I attended the deceased from Aug 23 1943 to April 21 1944
that I last saw h. in alive on April 18 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic fibro myocarditis

Due to _____

Due to _____

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

Major findings: Of operations 93d
Of autopsy _____

Duration

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) _____
(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) _____ (Means of injury)

23. Signature R. M. Stinson (M. D. or other) _____
Address Webb City, Mo Date signed Apr 24 44

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

MOTHER FATHER

44-4-301

OCT 11 1954.

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. *22859*

P. O. Address *West Nyack, N.Y.*

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.