

FILED AUG 10 1944

Registration District No. 23-104

Primary Registration District No. 5878

State File No. _____

Registrar's No. 19

1. PLACE OF DEATH:
(a) County Oregon
(b) City or town Alton Woodside Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 37 years (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Clinton W. 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 Married
6. (b) Name of husband or wife Hallie M. Braswell
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased July 18 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months 11 Days 4
If less than one day hr. _____ min. _____

9. Birthplace Boone County Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { **12. Name** Jacob J. Cline
13. Birthplace IOWA
(City, town, or county) (State or foreign country)
14. Maiden name Martha Caldwell
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clinton W. Cline
(b) Address Alton, Mo.

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 6/26/44
(Month) (Day) (Year)
(c) Place: burial or cremation Hickory Grove Cem.

18. (a) Signature of funeral director Geo. Carr
(b) Address Thayer, Mo.

19. (a) 5/27/1944 **(b) H. W. M. Cline**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Oregon 75
(c) City or town Alton (Rural) Woodside Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22
year 1944 hour 10 minute 45 A.M.
21. I hereby certify that I attended the deceased from July 1944 to July 22 1944
that I last saw him alive on _____ 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Heart Disease
Due to Arteriosclerosis
Chronic Gull Bladder Disease
Arteritis

Duration 1 year

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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) (e) Means of injury _____
23. Signature Geo. Carr (M. D. or other) _____
Address Thayer, Mo. **Date signed** 7-1-44

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 complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 200

Primary Registration District No. 5878

Registrar's No.

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Clinton W. Child

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced in

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

7. Birth date of deceased July 18 (Month) (Day) (Year)

8. AGE: Years 60 Months 11 Days _____ (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Henry M. Tolson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1944 hour _____ minute _____ M. 2

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

JAN 2 1945

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