

S. No. 2  
M-8-43  
5-17-39  
K37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16150  
Registrar's No. 37

FILED JUN 6 1946  
Registration District No. 96

Primary Registration District No. 5-35-6

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

1. PLACE OF DEATH:  
(a) County Dallas  
(b) City or town Long Lane Rural  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 yrs  
In this community 15 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Dallas  
(c) City or town Long Lane Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? 0  
If yes, name country 0

3. (a) PRINT FULL NAME ELSIE CLINE  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 4  
year 1946 hour 8 minute 45 A.M.

4. Female 5. Color or white  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Frank  
(c) Age of husband or wife if alive 50 years  
7. Birth date of deceased Sept 11 1903  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

8. AGE: Years 42 Months 7 Days 28  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Coronary Thrombosis  
Duration \_\_\_\_\_

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

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

10. Usual occupation Housekeeper

Major findings: Of operations 9/11  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Willie Manning  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Prisonette  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

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

16. (a) Informant: Frank Cline  
(b) Address Long Lane Mo  
17. (a) Burial (b) Date thereof 4-7-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bentley Branch

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? \_\_\_\_\_

18. (a) Signature of funeral director: L B Jones  
(b) Address Buffalo Mo  
19. (a) 6-2-46 (b) Ernest Petre  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature L B Jones (M. D. or other)  
Address Buffalo Mo Date signed 4-46

RECEIVED

Director of Health Officer No. 7,

DEPARTMENT OF HEALTH 5-46-521

Date Filed 6-5-46

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 Leonard E. Jones

Licensed Embalmer No. 2508

P. O. Address Buffalo, 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.