

FILED DEC 24 1946  
#6283

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42256

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10619

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.  
(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 month  
(Specify whether  
In this community 15 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1320 South Third Street  
Memorial (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10th  
year 1946 hour 2:10 minute P M.  
21. I hereby certify that I attended the deceased from 11/14/46  
19 to Dec. 10th 19 46  
that I last saw him alive on Dec. 10th 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
Bronchopneumonia, bilateral  
Pericarditis  
Duration 6 weeks  
4 weeks

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 107

Major findings:  
Of operations

Of autopsy As 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)  
(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) (or) Means of injury

23. Signature A.W. McLaughlin 1515 Lafayette 12/11/46  
Address Date signed

3. (a) PRINT FULL NAME BENNETT CLINE

3. (b) If veteran, name war nil 3. (c) Social Security No. none

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

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

7. Birth date of deceased March 10, 1873 (Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 0 If less than one day hr. min.

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

10. Usual occupation unemployed

11. Industry or business

12. Name Kinsey Cline

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

14. Maiden name Elizabeth Stewart

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

16. (a) Informant Octavia Coffel

(b) Address 1120 South Tenth Street

17. (a) burial (b) Date thereof 12-12-46 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New St. Marcus Cemetery

18. (c) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette Ave. St. Louis, Mo.

19. (a) DEC 11 1946 (b) A.W. McLaughlin (Date received local registrar) (Registrar's signature)

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 *H. K. Cooper*

Licensed Embalmer No. *31633*

P. O. Address. *2301 Lafayette*

**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.**