S. No. 2
I—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 4 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17837

Registration District No. 155 | Primary Registration District No. 5127 | Registrar's No. 90

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: 1225 W. Austin St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 35 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JASPER 49
(c) City or town ~~[illegible]~~ WEBB CITY 1
(If outside city or town limits, write "RURAL") 6
(d) Street No. 1225 W. Austin St 2
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME MARION WADSWORTH CLINE
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Clara Titus Cline
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased December (Month) 5 (Day) 1860 (Year)

8. AGE: Years 86 | Months 5 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ILLINOIS (State or foreign country)
10. Usual occupation Retired Farmer + Miller
11. Industry or business — — —
FATHER
12. Name CLINE
13. Birthplace unknown (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country) 9
16. (a) Informant MRS. MYRTLE SMITH
(b) Address Webb City, Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof May 31-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery
18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Mo
19. (a) MAY 29/1947 (Date received local registrar) (b) [signature] (Registrar's signature) 127

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1947 hour 3 minute 9 M.
21. I hereby certify that I attended the deceased from May 20, 1947, to May 29, 1947
that I last saw him alive on May 28, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

83A

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature R. M. Stormont (M.D. or other)
Address Webb City Mo Date signed 5/29/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

47-5-475

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 Lois A. Knell, Registered Apprentice No. 404, working under my personal supervision.

Signed Franklin W. Knell Jr

Licensed Embalmer No. 4440

P. O. Address Carthage

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.