

FILED DEC 9 1948  
Registration District No. **326**

Primary Registration District No. **C107**

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

1. PLACE OF DEATH:

(a) County **Scotland**  
(b) City or town **Granger MO**  
(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 **all her life** years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3: (a) PRINT FULL NAME **Charlotte Cline**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **17**  
year **1948** hour **6** minute **P.M.**

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.

4. Sex **Female** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **widow**  
6. (b) Name of husband or wife **Manuel Cline** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Dec 18 1854**  
(Month) (Day) (Year)

Immediate cause of death **Chronic myocarditis**  
Duration \_\_\_\_\_

8. AGE: Years **93** Months **7** Days **25** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace **Scotland Co MO**  
(City, town, or county) (State or foreign country)

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

10. Usual occupation **Housewife**

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

Major findings:  
Of operations **MI 30**  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

12. Name **John Rathburn**

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

14. Maiden name **Kathleen Corey**

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

16. (a) Informant **J. Cline**

(b) Address **Granger MO**

17. (a) Burial, cremation, or removal **Black oak** (b) Date thereof **Aug 15 1948**  
(Month) (Day) (Year)

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 **W. H. H. H.**

(b) Address **Memphis MO**

19. (a) **12/1/48** (b) **PM Baker**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury **MI**  
23. Signature **L. E. Rowe MD** (M. D. or other)  
Address **Memphis MO** Date signed **ang 20**

RECEIVED  
District Health Office No. 10  
District File Number 12-48-2088  
Date Filed DEC 7 - 1948

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 Fred Gerth

Licensed Embalmer No. 4256

P. O. Address Memphis

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.