

FILED APR 27 1949 THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12804**

BIRTH NO. 49-022729 REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Prairie 1st Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Grain Valley,</u>	
c. LENGTH OF STAY (In this place) <u>5 hrs.</u>		d. STREET ADDRESS (If rural, give location) <u>R. F. D. # 2</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Jackson Co. E. Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Albert</u> b. (Middle) <u>Marvin</u> c. (Last) <u>Cline Jr.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 21, 1949</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>1</u>	8. DATE OF BIRTH <u>March 21, 1949</u>	9. AGE (In years last birthday) <u>1</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Jackson County E. Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Albert Marvin Cline</u>	13b. MOTHER'S MAIDEN NAME <u>Dona Marie Pate</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Dona Marie Cline (Mother)</u>	ADDRESS <u>Grain Valley, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bilateral pulmonary atelectasis</u>		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>11/20</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-21-49, to 3-21-49; 1949, that I last saw the deceased alive on 3-21-49, 1949, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Donald C. Emshaw, M.D.</u> (Degree or title)	23b. ADDRESS <u>R # 4 Independence, Mo.</u>	23c. DATE SIGNED <u>3-21-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-22-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	24d. LOCATION (City, town, or county) (State) <u>Greenwood, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>3-22-49</u>	REGISTRAR'S SIGNATURE <u>Donald C. Emshaw</u>	378 FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Kangelord</u>	ADDRESS <u>Lee's Summit</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Not Embalmed

Licensed Embalmer No. _____

P. O. Address _____

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.