

MOURNERS DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035800

FILED VS NOV 2 1959

STATE FILE NUMBER

Registration District No. 122 Primary Registration District No. 2000 Registrar's No. 7116

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| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | Length of stay in lb <u>2 days</u> | c. CITY OR TOWN <u>Rural</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Springfield Rt. 3</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>EDWARD</u> Last <u>CLINE</u> | | | 4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/27/1888</u> | 9. AGE (last birthday) <u>71</u> | IF UNDER 1 YEAR Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. farming</u> | 11. BIRTHPLACE (City and state or country) <u>Forsythe, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Richard Cline</u> | | 13b. MOTHER'S MAIDEN NAME <u>Martha Barker</u> | | 14. NAME OF HUSBAND OR WIFE <u>Alberta Cline</u> | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>None</u> | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>R.F. D</u> Address <u># 3, Alberta Cline, Springfield, Mo.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> | | <u>3 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Arteriosclerotic heart disease</u> | <u>> 2 yrs</u> |
| DUE TO (c) | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | |

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|--|--|--|-------------------------|--------------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION <u>Springfield</u> | COUNTY <u>Greene</u> | STATE <u>Missouri</u> |
|--|--|--|-------------------------|--------------------------|

21. I attended the deceased from 2/20/59 to 10/17/59 and last saw her/him alive on 10/16/59
Death occurred at 12:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Andrew A. Allen M.D.</u> | (Degree of title) | 22b. ADDRESS <u>609 Cherry - Springfield Mo</u> | 22c. DATE SIGNED <u>10/22/59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>18 Oct. 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Bellview Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Springfield, Missouri.</u> |
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| 24. FUNERAL DIRECTOR <u>Ralph Thieme, Springfield, Missouri.</u> | 25. DATE RECD. BY LOCAL REG. <u>10-26-59</u> | 26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY APPOINTMENT OF

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 _____
Signature of Student Embalmer

Signed

Ralph H. Crum

Licensed Embalmer No.

3681

P. O. Address

Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.