

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Pettis Co
Township Washington
or
Village
or
City

Registration District No. 664 File No. 17849a
Primary Registration District No. 5384 Registered No.

2 FULL NAME Infant Albert & Cora Kinch

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>ma</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>	
DATE OF BIRTH <u>April</u> <u>27</u> <u>1918</u> (Month) (Day) (Year)			
AGE yrs. <u>1</u> mos. <u>2</u> ds.		If LESS than 1 day, hrs. or min.?	

OCCUPATION
Trade, profession, or
particular kind of work
General nature of industry
business or establishment in
which employed (or employer)

THPLACE
City or town,
or foreign country

10 NAME OF
FATHER Albert Kinch

11 BIRTHPLACE
OF FATHER
(City or town, State or foreign country) Ohio

12 MAIDEN NAME
OF MOTHER Cora Schnabel

13 BIRTHPLACE
OF MOTHER
(City or town, State or foreign country) Mo.

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant) W.F. LaFon
(Address) Windsor Mo.

ed. 8/9 1918 H.A. Hite
Registrar

2 MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH <u>May</u> <u>29</u> <u>1918</u> (Month) (Day) (Year)	
17 I HEREBY CERTIFY, that I attended deceased from 191..... to <u>May 29</u> 1918 that I last saw him alive on <u>May 29</u> 1918 and that death occurred, on the date stated above, at..... m. The CAUSE OF DEATH* was as follows: <u>Infantile Convulsions</u> <u>9</u> <u>86</u> (Duration) yrs. mos. ds. CONTRIBUTORY <u>Whooping Cough</u> (Secondary) (Duration) yrs. mos. ds. (Signed) <u>C.W. Head</u> M. D. <u>May 29</u> 1918 (Address) <u>Windsor</u>	
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted if not at place of death? Former or usual residence.	
19 PLACE OF BURIAL OR REMOVAL <u>Lonia</u>	DATE OF BURIAL <u>May 30</u> 1918
20 UNDERTAKER <u>W.E. Hutton</u>	ADDRESS <u>Windsor</u>

FORM XXX

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N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

(NO

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
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6 DATE OF BIRTH	(Month)	1 (Day)	(Year)
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7 AGE	yrs.	mos.	ds.
If LESS than 1 day.....hrs. or.....min.?			

8 OCCUPATION
(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
(City or town, State or foreign country)

10 NAME OF FATHER	11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed, 191

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH	(Month)	191	(Day)	(Year)
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17 I HEREBY CERTIFY, that I attended deceased from, 191, to, 191, that I last saw h..... alive on, 191, and that death occurred, on the date stated above, at, m. The CAUSE OF DEATH* was as follows:

(Duration)

CONTRIBUTORY
(Secondary)

(Duration)

(Signed), 191

(Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal. IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs. mos. ds. State yrs. mos. Where was disease contracted if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

191

REAL