

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

Do not use this space.

33209

1928

1. PLACE OF DEATH

County Craw Registration District No. 318

Township Springfield Primary Registration District No. 2001

City Springfield (No. St. John Hospital)

File No. 675

Registered No. 675 St. 3 Ward 5

2. FULL NAME

(a) Residence. No. Gainesville Mo. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Winnie Hinsley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/2/1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 42 1 2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labour P. R.
(b) General nature of industry, business, or establishment in which employed (or employer) Prisco
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Texas
(STATE OR COUNTRY)

10. NAME OF FATHER Thomas Hinsley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Texas
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Alice McAntye

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Texas
(STATE OR COUNTRY)

14. INFORMANT Mrs. Winnie Hinsley
(Address) Gainesville Mo.

15. FILE 11/14/27 REGISTRAR OCTOBER 27

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-4-1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1927, to Nov 4, 1927 that I last saw h. m. alive on Nov 4, 1927, and that death occurred, on the date stated above, at 2 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Empyema + Chronic
Pneumonia

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

Did AN OPERATION PRECEDE DEATH no DATE OF
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) Walter S. Lemell, M. D.

11-5, 1927 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Centerpoint Cemety DATE OF BURIAL 11-6 1927

20. UNDERTAKER Alma Lehman P. H. 534 1/2 Main ADDRESS

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

