

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

Do not use this space.

1. PLACE OF DEATH

County Randolph

Registration District No. 735

Township Moberly

Primary Registration District No. 3034

City Moberly

(Name) Wabash Hospital

File No. 34427
Registered No. 204
St. 2nd - Ward

2. FULL NAME

(a) Residence. No. 1521 Union St. 1st Ward.

(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 7th 1902

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
25 | 3 | 6 | — | — | —

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

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

10. NAME OF FATHER Joseph C Kinkaid

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

12. MAIDEN NAME OF MOTHER Susan Wycough

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

14. INFORMANT Mrs Elizabeth Kinkaid
(Address) Moberly Mo

15. FILED 11-14-27 Paul S Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 13th 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1927, to Nov. 13, 1927.
that I last saw h. l. m. alive on Nov. 13, 1927, and that death occurred, on the date stated above, at 4:20 P. m.

THE CAUSE OF DEATH** WAS AS FOLLOWS:
Compound fracture skull + lacerated brain
1948 ✓
(duration) yrs. mos. 2 ds.

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

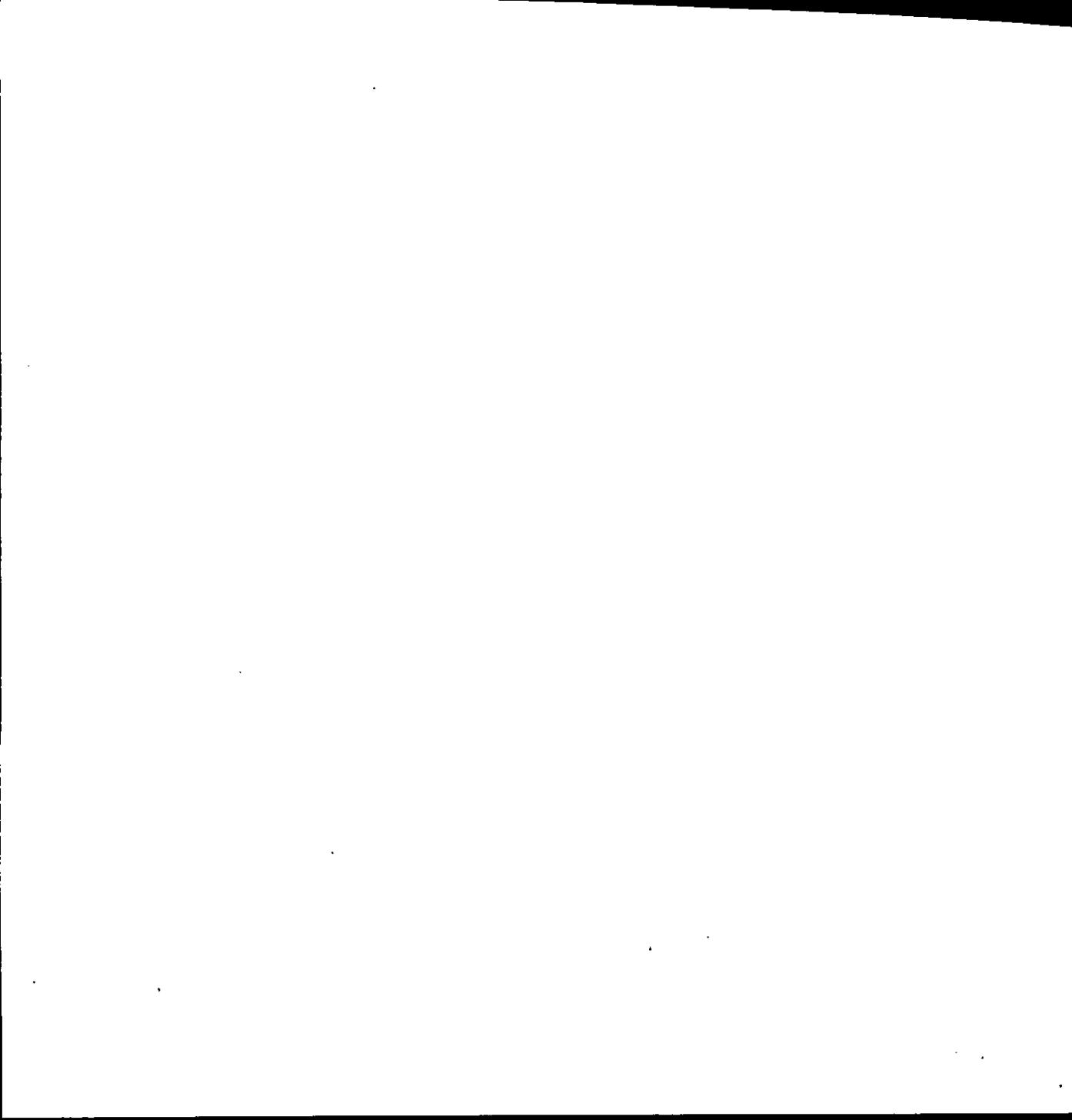
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: Salisbury
DID AN OPERATION PRECEDE DEATH: Yes DATE OF Nov 13/27

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) R. D. Streetor, M. D.
11-14-27 (Address) Moberly Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Moberly Mo DATE OF BURIAL 11-16th 1927

20. UNDERTAKER Mahan and Sew ADDRESS Moberly Mo



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Randolph

Registration District No. 735

File No. _____

Township _____

Primary Registration District No. 3034

Registered No. 204

City Moberly (No. _____)

St. _____

Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ 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 M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT _____
(Address)

15.

FILED 1-18-28 Thos S. Fleming
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 13 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Compound fracture skull & lacerated brain
Accidentally struck head against ledge when struck head out of Ry. engine cab.
CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. 1880

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) P. D. Steeter, M. D.
, 19____ (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-34427