

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

Do not use this space.

5439177

1928

1. PLACE OF DEATH
 County Shelby Registration District No. 830
 Township Rolling River Primary Registration District No. 6091
 City Shelbina (No.) St. Ward)

2. FULL NAME John David Hines
 (a) Residence Shelbina St. Ward.
 (Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 19 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 01 18

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 7 1927

17. I HEREBY CERTIFY That I attended deceased from Dec 4, 1927, to Dec 7, 1927 that I last saw him alive on Dec 7, 1927, and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
10.7
 (duration) yrs. mos. 1 da.

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

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

10. NAME OF FATHER Henry Hines

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

12. MAIDEN NAME OF MOTHER Missie Evans

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) J. D. Morris, 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.

14. INFORMANT Bertha Browning
 (Address) Shelbina, Mo.

15. FILED Dec 10 27 Wedge Good
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Shelbina DATE OF BURIAL Dec 9 1927

20. UNDERTAKER Gona Peter ADDRESS Shelbina Mo.

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.

Every item of information should be stated in plain terms, so that it may be understood by the general public. Exactness of OCCURRENCE is a primary consideration.

REMARKS: _____

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Shelby
Township Salt River
City..... (No....., St. Ward)

Registration District No. 830
Primary Registration District No. 6091

File No. 34
Registered No.
St. Ward

2. FULL NAME

John David Hines

(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 (write the word) m

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)

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 Dec 27 Madg. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 7 1927

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

pneumonia
bronchial
..... (duration) yrs. mos. ds. X
CONTRIBUTORY (SECONDARY) 1000
..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., 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

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information must be carefully supplied. AGE should be stated. CAUSE OF DEATH, if not stated, may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED.

SUPPLEMENTARY

S-39179