

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

Do not use this space.

5882

1. PLACE OF DEATH

County..... *Cole*
Township..... *Clark*
City..... (No.) St. Ward

Registration District No. *212*
Primary Registration District No. *5292*

File No.
Registered No. *4*

2. FULL NAME

Mathew Washington Hinds

(a) Residence. No. St. Ward

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. (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 (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *aug 18 - 1867*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 | 6 | 2

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.....

9. BIRTHPLACE (CITY OR TOWN) *Cole co mo*
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Joseph Hinds*

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

12. MAIDEN NAME OF MOTHER *Martha Johnston*

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

14. INFORMANT *Nile Hinds*
(Address) *Eugene Mo.*

15. FILED *Mar 11 19 29* *T. L. Glover*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 10 19 29*

17. I HEREBY CERTIFY That I attended deceased from *Jan 7*, 19*29*, to *Jan 9*, 19*29*, that I last saw him alive on *Jan 9*, 19*29*, and that death occurred, on the date stated above, at *3 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11th Influenza
(duration) yrs. mos. *10* da.

CONTRIBUTORY (SECONDARY) *Lobar Pneumonia*
(duration) yrs. mos. *2* da.

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

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Dr T. L. Glover*, M. D.
Feb 10, 19 29 (Address) *Eugene Mo*

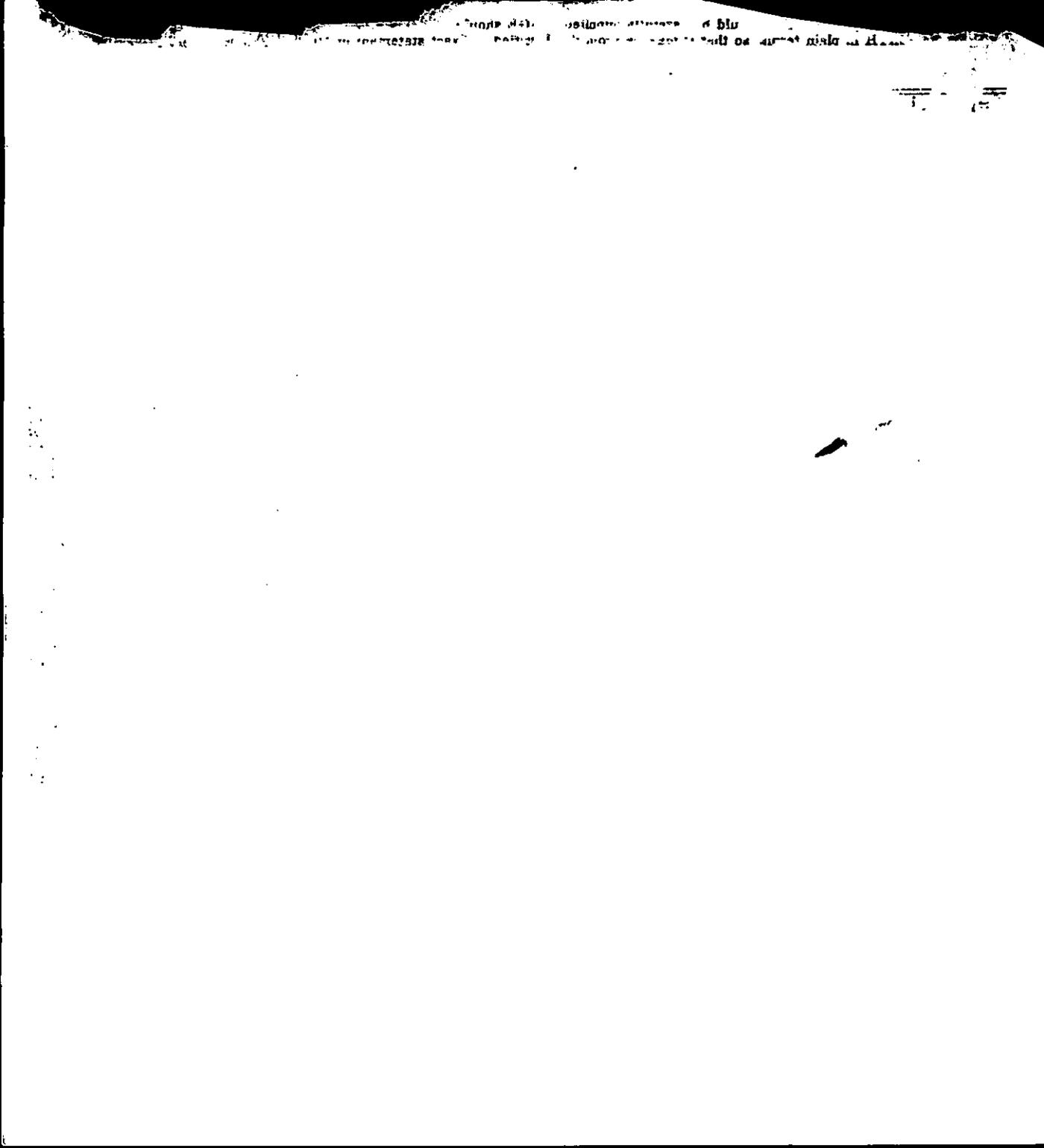
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Spring Garden Cem* DATE OF BURIAL *Feb 12 19 29*

20. UNDERTAKER *G. N. Steffens* ADDRESS *Russellville*

CAUSE OF DEATH should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important.

81 0229
61-5-22



**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 Polk
Township Clark
City Clark (No. _____) St. _____ Ward _____

Registration District No. 212
Primary Registration District No. 3292

File No. _____
Registered No. 4

2. FULL NAME

Mathew Washington Hinds

(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)

Aug 18-1867

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

61

5

22

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 Mar 11 1929

T. L. Glover
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 10 1929 19

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:

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

(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 should be carefully supplied. AGE should be given in FULLY. PHYSICIAN'S should be stated. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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