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

Do not use this space.

38193-a

25 1930

1. PLACE OF DEATH
County St. Francois
Township St. Francois
City Farmington, Mo. (No. ..... St. ..... Ward)
Registration District No. [illegible]
Primary Registration District No. [illegible]
File No. .....
Registered No. .....

2. FULL NAME George C. Hines
(a) Residence. No. Beal, Mo. 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. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
73			

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) Bolen Green
(STATE OR COUNTRY) Kentucky.

PARENTS
10. NAME OF FATHER George A. Hines
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Elizabeth Roan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

14. INFORMANT Hospital Records
(Address) Farmington, Mo.

15. FILED ....., 19.....
REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11 - 2 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1929, to Nov 2, 1929 that I last saw him alive on Nov 2, 1929, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy
BCA
97 (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Arterio Sclerosis
(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? clinical
(Signed) P J Lair, M. D.
, 19 (Address) Hoop #4 Farmington 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	DATE OF BURIAL
Beal.	11/6/ 1929
20. UNDERTAKER	ADDRESS

Statement of OCCUPATION is very important.

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 St Francois Registration District No. 773 File No.
Township Primary Registration District No. ~~4467~~ 6018A Registered No. 115
Near City Farmington (No. St. Ward)

2. FULL NAME George C. Hines
(a) Residence. No. Beal Mo 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. 1 mos. 1 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 Beatrice LeGrand

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 19, 1856

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
73	4	10	

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) Bolen Green
(STATE OR COUNTRY) Kentucky

PARENTS
10. NAME OF FATHER George C. Hines
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Elizabeth Roan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky

14. INFORMANT Hospital Records
(Address) Farmington MO

15. FILED Aug 6 1930 B. J. Robinson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov - 2 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1929 to Nov 2, 1929 that I last saw him alive on Nov 2, 1929 and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral apoplexy
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterio sclerosis
(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? Clinical
(Signed) P. S. Tate, M. D
(Address) Hospital #4 Farmington 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 Beal Mo
DATE OF BURIAL 11/6 1929

20. UNDERTAKER Unknown
ADDRESS Unknown

SUPPLEMENTARY

THEY ARE COMPLETE AS PRESCRIBED BY LA
SHALL NOT RECEIVE A
REGIST

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