

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

Do not use this space.

17146

1. PLACE OF DEATH

County St. Francois
 Township St. Francois
 City Farmington, Mo. (No. _____ St. _____ Ward)

Registration District No. 773
 Primary Registration District No. 6018A

File No. _____
 Registered No. 82

2. FULL NAME Johnathan Lincoln

(a) Residence. No. Wappapello, 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. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

Unknown

7. AGE

YEARS	MONTHS	DAY	If LESS than 1 day, hrs. or min.
81	?	?	

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)

(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Hospital Records.

(Address) Farmington, Mo.

15. FILED 6/3/30 B. G. Robinson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930 to May 31, 1930 that I last saw him alive on May 31, 1930 and that death occurred, on the date stated above, at 8:55 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

930 Chronic Myocarditis
64 (duration) 3 yrs. mos. ds.
102 CONTRIBUTORY Insanity (senile dementia)
 (SECONDARY) (duration) 3 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) J. C. Fincher, M. D.

June 3 1930 (Address) 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**

McC Lee, Mo. June 4 1930
20. UNDERTAKER ADDRESS

Farmington L. Co. Farmington
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.

DEPARTMENT RECORD

SUN 27 1930

29

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