

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

Do not use this space.

5302

1. PLACE OF DEATH

36 County Franklin Registration District No. 293
Township Bolea Primary Registration District No. 5411
City _____ (No. _____) _____ St. _____ Ward _____

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME Samuel Hinkle

(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 Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE 60 YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(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) Mo

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Do not know

14. INFORMANT Frank Hinkle (Address) Labadie Mo

15. FILED Feb - 12 19 33 W. M. Thibaut REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 12 1933

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1933, to Feb 8 1933. that I last saw him alive on Feb 8 1933, and that death occurred, on the date stated above, at 3:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
93D Bronche Pneumonia
107A 93 D
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Myocarditis
(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? (Signed) McMuller M. D.

Feb 12 1933 (Address) Labadie 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 Labadie Mo DATE OF BURIAL 2-12 1933

20. UNDERTAKER J. a. Thibaut ADDRESS Pacific

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

