

EB 27 1934

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

Do not use this space.

1726

1. PLACE OF DEATH

County Lafayette

Registration District No. 460

Township Devis

Primary Registration District No. 4274

City Higginsville, (No. 4)  
James P. Chinn

File No. ....

Registered No. 10

St. .... Ward

2. FULL NAME

(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 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) June 21st 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 70 6 27

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Lawyer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lafayette Co. Mo.

13. NAME Hector Chinn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Francis Pedicord

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) James Brockman Higginsville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE City Cemetery 1/20/38, 1938

19. UNDERTAKER (ADDRESS) W. S. W. Higginsville, Mo.

20. FILED 1-20-, 1934 Dr. W. A. Bracklein Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 18, 1934

22. I HEREBY CERTIFY, That I attended deceased from January 15, 1934 to January 18, 1934  
I last saw him alive on January 18, 1934. Death is said to have occurred on the date stated above, at 11:40 am.  
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset 1/7/34

Other contributory causes of importance:

Diabetes

Name of operation None Date of 1/17/34  
What test confirmed diagnosis? Cl. Phys. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury  
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify  
(Signed) W. Carson Davis, M. D.  
(Address) Higginsville, Mo.

1954

**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 Lafayette  
Township  
City Higginsville (No. .... St. .... Ward)

Registration District No. 460  
Primary Registration District No. 7274

File No. 1726  
Registered No. ....

**2. FULL NAME**

James O. Quinn

(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) D.  
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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 19 70-6-1934 Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 18, 1934

22. I HEREBY CERTIFY That I attended deceased from ..... to ..... 19.....

I last saw h..... alive on ..... 19..... Death is said

to have occurred on the date stated above, at..... m.  
The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Date of onset

Other contributory causes of importance:

Diabetes melitus

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify ..... (Signed) ....., M. D.

(Address) .....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE OF DEATH

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