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

Do not use this space.

MAY 25 1934

File No. 12509

Registered No.

1. PLACE OF DEATH

County: Greene — Registration District No. 317

Township: — Primary Registration District No. 4192

City: Republic, Mo. (No. ..... St. ..... Ward)

2. FULL NAME: William Thomas Pinegar

(a) Residence, No. Republic, Mo. St., ..... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—Every item of information should be carefully supp... 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.

ERMANENT RECORD

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan. 3, 1859

7. AGE: Years 75 — Months 3 — Days 7 — If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: retired
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): Illinois

FATHER

13. NAME: Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

MOTHER

15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Mrs. Victor Williams, Republic, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Cemetery at Conway DATE: Apr. 12, 1934

19. UNDERTAKER (ADDRESS): R. E. Thurman & Co., Republic, Mo.

20. FILED: 4/11, 1934 — Registrar.

## 3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): April 10th, 1934

22. I HEREBY CERTIFY, That I attended deceased from April 7th, 1934, to April 10th, 1934

I last saw him alive on April 10th 1934. Death is said to have occurred on the date stated above, at 12:30 P.M.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Myocarditis | |
| Enlarged Heart | |

Other contributory causes of importance:

Arteriosclerosis

Name of operation: None — Date of: No

What test confirmed diagnosis? Clinical — 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? ←

If so, specify ← ← ←

(Signed) D. H. Mitch M.D.

(Address) Republic, Mo. D.O.

WRITE PLAINLY, WITH UNFADING INK—THIS [illegible] d EXACTLY. PHYSICIANS should state CAUSE OF DEATH [illegible] statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTI[illegible]ES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

# 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: Greene — Registration District No. 317

Township: — Primary Registration District No. 4192

City: Republic (No. ..... St. ..... Ward)

File No. .....

Registered No. .....

**2. FULL NAME** Wm. Thomas Cunegar

(a) Residence, No. ..... St., ..... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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): W

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.

OCCUPATION

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)

FATHER

13. NAME .....

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

MOTHER

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 April 12 1934 Mrs Bertha Nance Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 10 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:

| | Date of onset |
|---|---|
| | |
| | |
| | |
| | |
| | |

Other contributory causes of importance:

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

5-12-509