

REC'D FEB 21 1939

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

1704
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township..... Primary Registration District No. 1001 Registered No. 102
 (c) City St. Joseph (d) Street No. 428 N. 21st Street, St.
 (e) Length of residence in city or town where death occurred 55 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Sherman Kinnison

(a) Residence, No. 428 N. 21st St. St. Joseph, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Bertha Marie Kinnison
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 6, 1866
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 3 25
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. retired druggist
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (CITY OR TOWN) Andrew County, Missouri. (STATE OR COUNTRY)

FATHER 13. NAME Cyrus Jefferson Kinnison

14. BIRTHPLACE (CITY OR TOWN) Jackson County Ohio (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Abigail Jones

16. BIRTHPLACE (CITY OR TOWN) Wayne County Indiana (STATE OR COUNTRY)

17. INFORMANT William Max Kinnison (ADDRESS) 30th & Francis, St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park Cem DATE Feb. 2, 1939

19. FUNERAL DIRECTOR (NAME) Walter Meierhoffer (ADDRESS) 1302 Faraon St., St. Joseph, Mo.

20. FILED Feb 2 1939 H. J. Neidlich Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 31, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1938, to 1-31-1939, 1939

I last saw him alive on 1-31-39, 1939 Death is said to have occurred on the date stated above, at 9:15p.m.

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

acute glomerular nephritis

Date of onset

1/27/39

Other contributory causes of importance:

arterio sclerosis

Name of operation..... Date of.....

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? no

If so, specify

(Signed) L. Bauman, M. D.

(Address) Kirkpatrick Bldg. St. Joseph, 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 im.

1159

130

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Wilbur Kelly

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

W. H. Kelly

Licensed Embalmer No. Mo. 3946

P. O. Address St. Joseph, Missouri.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

Missouri State Board of Health
Department of Health
St. Joseph, Missouri

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

1704
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85-
(b) Township St Joseph Primary Registration District No. 1001 Registered No. 102
(c) City St Joseph (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Sherman Harrison

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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.
72 3 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19 _____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-31 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, 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:

acute glomerular nephritis 97
Chronic Uremia
Other contributory causes of importance: arterio sclerosis

Date of onset

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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) L. C. Bannan, M. D.

(Address) St Joseph Bldg.
St Joseph, Mo.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTERARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED.

SUPPLEMENTAL

