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.

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

REC'D MAY 10 1939

13748
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Kaw — Primary Registration District No. 1002 — Registered No. 1502
(c) City Kansas City, Mo (d) Street No. 4471 Pennsylvania 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 520 James Arthur Hinshaw
(a) Residence, No. 4471 Pennsylvania St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mrs. Johanna H. Hinshaw
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Apr. 28, 1876
7. AGE: YEARS 62 — MONTHS 11 — DAYS 8 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Real Estate
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): Illinois

FATHER
13. NAME: Nathan Hinshaw
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

MOTHER
15. MAIDEN NAME: Sarah Ayers
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

17. INFORMANT (ADDRESS): Mrs. Johanna Hinshaw, 4471 Pennsylvania
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Moriah DATE Apr. 8, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): R. V. Lindsey & Sons, 3811 Broadway
20. FILED Apr 8, 1939 M. M. Crowe, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Apr. 6, 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 4:45 m. PM
Deputy Coroner
The principal cause of death and related causes of importance were as follows:
Acute & chronic ulcerative cholecystitis & cholelithiasis
Rupture of the gall bladder
Date of onset
Other contributory causes of importance:
Early acute localized peritonitis
Name of operation 126 Date of
What test confirmed diagnosis? Was there an autopsy? Yes
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) [signature], M. D.
(Address) Gen. Hosp. K. C. Mo

(Licensed Embalmer's Statement on Reverse Side)

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, ...

....., or by .....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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