

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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**

35675
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 125
 (b) Township Cape Girardeau Primary Registration District No. 3909
 (c) City Cape Girardeau (d) Street No. South East Missouri Hospital 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 536 Manson Kinder 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) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Tisha Kinder
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 22 1874
 7. AGE YEARS 65 MONTHS 2 DAYS 13 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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) Ballinger Co. Mo.

FATHER 13. NAME James V. Kinder
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ballinger Co. Mo.

MOTHER 15. MAIDEN NAME Sarah Jane Presnell
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ballinger Co. Mo.

17. INFORMANT Willis Kinder Millerwick
 (ADDRESS) Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Sedgewickville Mo. DATE Sept 7 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Maude Wilson State Jackson Mo.

20. FILED 10-5-39 Wm. Thompson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-5-1939

22. I HEREBY CERTIFY, That I attended deceased from 10-2-1939 to 10-5-1939

I last saw him alive on 10-5-1939. Death is said to have occurred on the date stated above, at 4:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Acute Myocarditis

Other contributory causes of importance:
Suppressed function of Kidneys

Name of operation Subraty 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? No
 If so, specify

(Signed) Alfred M. Estes M. D.
 (Address) Jackson, Mo.

7-28-68

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,

by me

....., or by

Registered Apprentice No., working under my personal supervision.

Signed *Glenn Wilson*

Licensed Embalmer No. *2828*

P. O. Address *Jackson Mo*

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.