

Registration District No. 97

Primary Registration District No. 5143

Registrar's No. 10

1. PLACE OF DEATH: Caldwell Co.
 (a) County Rural Kidder
 (b) City or town (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location) No
 (d) Length of stay: In hospital or institution (Specify whether)
 In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Caldwell
 Rural.
 (c) City or town (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? years

3. (a) PRINT FULL NAME Catherine Kinsella 524
 (b) If veteran, name war
 (c) Social Security No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug 21 1940
 year hour 3:45 PM minute M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 (b) Name of husband or wife Michael Kinsella
 (c) Age of husband or wife if alive years 24 1860
 7. Birth date of deceased (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 20 1932 to Aug 21 1940;
 that I last saw her alive on Aug 17 1940;
 and that death occurred on the date and hour stated above.
 Immediate cause of death Arteriosclerosis
 Duration

8. AGE: Years 80 1/2 Months 4 Days 27 If less than one day hr. min.

Due to
 Due to
 Other conditions (Include pregnancy within 3 months of death)
 Major findings:
 Of operations
 Of autopsy

9. Birthplace Illinois (City, town, or county) (State or foreign country)
 10. Usual occupation At home

11. Industry or business
 12. Name James De Voy.
 13. Birthplace Ireland (State or foreign country)
 14. Maiden name Anna Kinsella
 15. Birthplace Ireland (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Michael Kinsella
 (b) Address Caldwell Co.
 17. (a) Burial (b) Date thereof 8-23-40 (Month) (Day) (Year)
 (c) Place: burial or cremation Catholic Cem.
 18. (a) Signature of funeral director Poland Funeral Home
 (b) Address Cameron
 19. (a) Date received local registrar Aug. 23-40 (b) H. F. Powell (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work (Specify type of injury) (e) M. D. or other)
 23. Signature Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 11,

District File Number

940-1401

Date Filed

SEP 12 1940

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

James Scott Luckshon

Licensed Embalmer No.

4092

P. O. Address

Cameron Mission

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **28114**

Registration District No. **97**

Primary Registration District No. **3143**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County **Caldwell**
 (b) City or town **Miller T.P.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Catherine Kinsella**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased **Mar 24 1860**
(Month) (Day) (Year)

8. AGE: Years **80** Months **4** Days **27**
If less than one day hr. min.

9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....
(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **Oct. 5** (b) **H. F. Powell**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town.....
(If outside city or town limits write "RURAL")
 (d) Street No.....
(If rural, give location)
 (e) If foreign born, how long in U. S. A.?..... years.

PERMITS AND CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **21**
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
 that I last saw h..... alive on....., 19.....;
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?.....
(Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

