

Registration District No. 384 Primary Registration District No. 4227

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Howell  
 (a) County Howell  
 (b) City or town West Plains  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Christa Hogan Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days  
 In this community 45 years  
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME WM KARL PIRNACK  
 8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Agnes Weible 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Sept 4 1861  
 (Month) (Day) (Year)

8. AGE: Years 79 Months 0 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Baker

11. Industry or business Retired

MOTHER FATHER  
 12. Name unknown  
 13. Birthplace unknown Germany  
 (City, town, or county) (State or foreign country)  
 14. Maiden name unknown  
 15. Birthplace unknown Germany  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chris Pirnack  
 (b) Address West Plains, Mo

17. (a) Burial (b) Date thereof Sept 11, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director Lawrence Carr  
 (b) Address West Plains Mo

19. (a) 9-1-40 (b) Vida W SIMONS  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Howell  
 (c) City or town West Plains  
 (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.? 57 years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept. day 9  
 year 1940 hour 3 minute 10 P. M.

21. I hereby certify that I attended the deceased from July 1 1940 to September 9 1940  
 and that death occurred on the date and hour stated above.  
 that I last saw him alive on September 9 1940

Immediate cause of death Pneumonia Duration 3 1/2 wks  
 Due to Cancer of Mortale  
and Diabetes  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: None  
 Of operations \_\_\_\_\_

Of autopsy None

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? Yes

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

23. Signature W. H. [Signature] (If other) \_\_\_\_\_  
 Address West Plains, Mo. Date signed \_\_\_\_\_

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.

RECEIVED

District Health Officer No. 5,

District File Number 1040975

Date Filed \_\_\_\_\_

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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 Lawrence Carr

Licensed Embalmer No. 4031

P. O. Address West Plains, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **32169**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **384**

Primary Registration District No. **4237**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Houssain**  
(b) City or town **West Plains**  
(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 **Wm Karl Pinnacker**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **w**

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

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years **79** Months **0** Days **5** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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: (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) **9-11-40** (b) **Vida W. Simons** (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **9** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial pneumonia** Duration \_\_\_\_\_

Due to **Cancer of Prostate and bladder**

Due to **CANCER of Prostate**

Other conditions: (Include pregnancy within 3 months of death) **51**

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) (c) Means of injury \_\_\_\_\_

23. Signature **P. E. Hogan** (M. D. or other) **MD**  
Address **West Plains, Mo** Date signed \_\_\_\_\_

SUPPLEMENTAL

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

