

JAN 23 1941 STANDARD CERTIFICATE OF DEATH

State File No. **44052**

Registration District No. **822** Primary Registration District No. **10081** Registrar's No. _____

I. PLACE OF DEATH

(a) County **Shannon**
 (b) City or town **Rural Jasper Twp**
(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 **4 man** years, months or days **2**

3. (a) PRINT FULL NAME **Edward E. Sinclair**

8. (b) If veteran, name war **X** 8. (c) Social Security No. **X**

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

6. (b) Name of husband or wife **Janis Sinclair** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **Mar 20 188**
(Month) (Day) (Year)

8. AGE: Years **56** Months **8** Days **19** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Farmer** **0**

11. Industry or business
 MOTHER FATHER { 12. Name **Eugene Sinclair** **1**
 13. Birthplace **Palla** **MO**
(City, town, or county) (State or foreign country)
 14. Maiden name **Josephine Brown**
 15. Birthplace **Wrahaout** **Ind**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lillie Finney**
 (b) Address **Duck MO**

17. (a) **Burial** (b) Date thereof **Dec 10 - 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Summersville MO**

18. (a) Signature of funeral director **Ray Day**

(b) Address **Summersville MO**

19. (a) **12-9-40** (b) **Frank Boyd MD**
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Shannon**
 (c) City or town **Rural Jasper Twp**
(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 **Dec** day **9**
 year **1940** hour **2** minute **0** P. M.

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

Immediate cause of death **Physicist Retired**
Complicated by Influenza
 Due to _____

Due to _____
 Other conditions **11 W**
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

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?
not at

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

23. Signature **Frank Boyd** (M. D. or other) **1**
 Address **Summersville MO** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 12401212

Date Filed _____

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 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. 44059

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 822

Primary Registration District No. 6081

Registrar's No. _____

1. PLACE OF DEATH?

(a) County Shannon
(b) City or town Gasper T.P.
(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 Edward E. Sinclair

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 none
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 56 Months 8 Days 19 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) 12-9-40 (b) Frank Hyde MD (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 Dec day 8 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 _____

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 Frank Hyde (M. D. or other) _____

Address Emmerson Date signed _____

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

SUPPLEMENTAL

