

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.

NOV 25 1941

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

Do not use this space.

1. PLACE OF DEATH

County  
Township  
City

Registration District No.

Primary Registration District No.

(No)

File No.

Registered No.

St.

Ward

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

823

6074

4550

101

0

0

George S. Sinclair  
Shannon Co, Mo. Rural

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Unmarried

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF

Josephine Sinclair

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Mar 24 1854

7. AGE

86

MONTHS

10

DAYS

24

If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Farmer

9. Industry or business in which work was done, as silk mill, 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)

St. James, Mo

13. NAME

James Sinclair

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Don't know

15. MAIDEN NAME

Charity McComie

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unknown?

17. INFORMANT (ADDRESS)

Arthur Hiney

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19. UNDERTAKER (ADDRESS)

Ray H. Hall  
Funeral Home & Crematory

20. FILED

1-30

1941

Frank Hyde MD Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

Jan. 24 1941

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..... m.

The principal cause of death and related causes of importance were as follows:

Influenza Jan 10

Other contributory causes of importance:

Valvular Heart Disease

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

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)

Dr. J. M. Reed, M.D.  
Summersville, Mo

RECEIVED

District Health Officer No. 5,

District File Number. 241275

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4530

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 823

Primary Registration District No. 6074

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Shannon, Mo.  
(b) City or town Warrensburg  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Geo. W. 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 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 1899  
(Month) (Day) (Year)

8. AGE: Years 86 Months 10 Days 24 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) 1-24-41 (b) Frank T. G. de M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon  
(c) City or town Rural  
(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24  
year 1941 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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(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? \_\_\_\_\_

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

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

Address Summersville Missouri

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

