

Registration District No. 499

Primary Registration District No. 5664

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Rural, Clay Twp.
(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 1
In this community _____
years, months or days

3. (a) PRINT FULL NAME William Jonathan Rinker

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nancy E. Rinker 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 8-- 1867
(Month) (Day) (Year)

8. AGE: Years 74 Months 1 Days 17 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Robert F. Rinker

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

14. Maiden name Julia A. Brinkley

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

16. (a) Informant's own signature Rob F. Rinker
(b) Address Oto Iowa

17. (a) Burial (b) Date thereof 2/27/1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Thorne & Co.
(b) Address Linneus, Missouri

19. (a) 3-72-41 (b) Geo. H. Clarkson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn
(c) City or town Rural, Clay Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25
year 1941 hour 10 minute 30 a. M.

21. I hereby certify that I attended the deceased from Feb 25
1 A.M., 1941 to Feb 25 10:30 AM, 1941;
that I last saw him alive on Feb 25, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Shock

Due to Renal calculi history of XRAY picture

Due to _____

Other conditions 0 34
(Include pregnancy within 3 months of death)

Major findings:
Of operations 0

Of autopsy 0

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

23. Signature W. H. Morrison (M. D. or other) _____
Address Wheeling, Missouri Date signed 2/26

Duration

12 hrs

Exam

known

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

REV. 5-17-39 I 12511

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..... *David A. Taylor*

Licensed Embalmer No..... 3761

P. O. Address..... Linneus, Missouri

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.