

FILED APR 15 1941

State File No. \_\_\_\_\_

Registration District No. 690

Primary Registration District No. 5918

Registrar's No. 4

## 1. PLACE OF DEATH:

(a) County: Pike  
 (b) City or town: Middletown Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: None  
 (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)

## 2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME: Nona B McCoy3. (b) If veteran, name war —3. (c) Social Security No. —4. Sex: F5. Color or race: W6. (a) Single, widowed, married, divorced: Married6. (b) Name of husband or wife: Wm McCoy6. (c) Age of husband or wife if alive: 70 years7. Birth date of deceased: Dec. 1 1873  
(Month) (Day) (Year)8. AGE: Years: 67 Months: 2 Days: 27  
If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace: Pike County Mo (City, town, or county) (State or foreign country)10. Usual occupation: Housewife

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

12. Name: Michael Rinkel13. Birthplace: St Louis Mo (City, town, or county) (State or foreign country)14. Maiden name: Elizabeth Rinkel15. Birthplace: Philadelphia Pa (City, town, or county) (State or foreign country)16. (a) Informant: Blanche McCoy(b) Address: Middletown Mo17. (a) Burial (b) Date thereof: Mar 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation: Wm Payne Cem18. (a) Signature of funeral director: Precher Kuhn(b) Address: Middletown Mo19. (a) Mar 1 - 1941 (b) Mrs Liss Moore  
(Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb day: 28  
year: 1941 hour: 3 P.M. minute: \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from Oct. 21  
1939, to Feb. 28, 1941;that I last saw her alive on Feb. 22, 1941;

and that death occurred on the date and hour stated above.

Immediate cause of death: brems comaDue to: chronic nephritis

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

Other conditions: 171  
(Include pregnancy within 3 months of death)Major findings: None

Of operations: \_\_\_\_\_

Of autopsy: None

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: Lucas Ransom (M. D. or other) —  
Address: Badling Green Mo Date signed: 3/1/41

Duration:

PHYSICIAN

Underline the cause to which death should be charged statistically.

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

District Health Officer No. 10

District File Number 4-41-65-9

Date Filed APR 10 1941

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.

*[Handwritten Signature]*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

2  
41  
39  
26390

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11709

Registration District No. 690

Primary Registration District No. 5918

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

1. PLACE OF DEATH:

(a) County Putnam  
(b) City or town Hartford 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

Mona B. McCoy

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 m  
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 Months Days If less than one day  
67 2 27 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 Philadelphia, Penn. (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

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

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

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

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

19. (a) Mar 1 - 41 (b) Mrs. Lynn Moore  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

Duration

Duration \_\_\_\_\_

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 Eugene Barrymore (M. D. or other) \_\_\_\_\_  
Address Bowling Green Mo. Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PLACE FOR STAMP RECORD

11709

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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.....

..... Licensed Embalmer No.....

..... P. O. Address.....

**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.**