

Registration District No. 796

Primary Registration District No. 3038

Registrar's No. 81

1. PLACE OF DEATH: Saline

(a) County: Saline

(b) City or town: Marshall  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fitzgibbon hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 day  
(Specify whether Allier life)

In this community: years, months or days

3. (a) PRINT FULL NAME: Katheleen Hinton

3. (b) If veteran, name war: X

3. (c) Social Security No.: X

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Raymond Hinton

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Nov. 11, 1903  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>37</u>	<u>5</u>	<u>15</u>	hr. min.

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

10. Usual occupation: Housewife

11. Industry or business: "

12. Name: Clarence Chaoman

13. Birthplace: Marshall, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name: Maggie Warner

15. Birthplace: Marshall, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant: Raymond Hinton

(b) Address: Napton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-28-41  
(Month) (Day) (Year)

(c) Place: burial or cremation: Ridge Park Cem.

18. (a) Signature of funeral director: J. Leslie Stacey

(b) Address: Marshall, Mo.

19. (a) 5-1-41 (Date received local registrar) (b) Deputy (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Saline 97

(c) City or town: Napton, R.F.D.  
(If outside city or town limits, write "RURAL") 0

(d) Street No.: 0  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April day: 26  
year: 1941 hour: 8: minute: 3.0 P. M.

21. I hereby certify that I attended the deceased from April 25, 1941, to April 26, 1941; that I last saw her alive on April 26, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia

Due to: Pneumonia

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? \_\_\_\_\_

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

23. Signature: Richard A. Aymer (M. D. or other) MD

Address: Marshall, Mo. Date signed: 5-1-

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

110  
RECEIVED  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed 5-19-41

**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 J. Leslie Sweeney  
Licensed Embalmer No. 3235  
P. O. Address Marshall, W. Va.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15960

Registration District No. 796

Primary Registration District No. 3038

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

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall  
(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 years, months or days)

In this community \_\_\_\_\_

3. (a) PRINT FULL NAME Kathleen Henton

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 W

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

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

8. AGE: Years Months Days If less than one day

37 5 15 hr. min.

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

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

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

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) \_\_\_\_\_ (b) \_\_\_\_\_ (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 Apr day 26  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

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

Immediate cause of death Pulmonary Empysemia Duration \_\_\_\_\_

Due to Pneumonia

Due to Labar

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 [Signature] (M. D. or other) \_\_\_\_\_

Address Marshall Mo Date signed \_\_\_\_\_

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

LOWENA MOORE

SUPPLEMENTARY

S-15960