

FILLED SEP 11 1941

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

Do not use this space.

29217

1. PLACE OF DEATH

County St Charles
Township Callaway
City (No.)

Registration District No. 459
Primary Registration District No. 6000

File No.
Registered No. Ward

2. FULL NAME Herman August Hinnah

(a) Residence, No. St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Louise Hinnah</u>			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 29, 1861</u>			
7. AGE YEARS <u>79</u>	MONTHS <u>10</u>	DAYS <u>14</u>	If LESS than 1 day, <u> </u> hrs. or <u> </u> min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as <u>sawyer, bookkeeper, etc.</u>
	9. Industry or business in which work was done, as <u>silk mill, saw mill, bank, etc.</u>
	10. Date deceased last worked at this occupation (month and year) <u>Aug, 1941</u>
	11. Total time (years) spent in this occupation <u> </u>

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Germany

13. NAME William Hinnah

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

15. MAIDEN NAME Dont Know

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

17. INFORMANT Louise Hinnah
(ADDRESS) New Melle, MO

18. BURIAL, CREMATION, OR REMOVAL
PLACE Caplian Mo DATE Aug, 16 1941

19. UNDERTAKER Marion Murphree
(ADDRESS) 8/15 New Melle Mo

20. FILED 46 Pertude, S. Forister
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19

22. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1941, to Aug 13, 1941.
I last saw him (alive) on Aug 8, 1941. Death is said to have occurred on the date stated above, at 11 P. m.

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

Chronic myocarditis
with general atherosclerosis
Arterio Sclerosis
Date of onset 1940

Other contributory causes of importance:
Renal

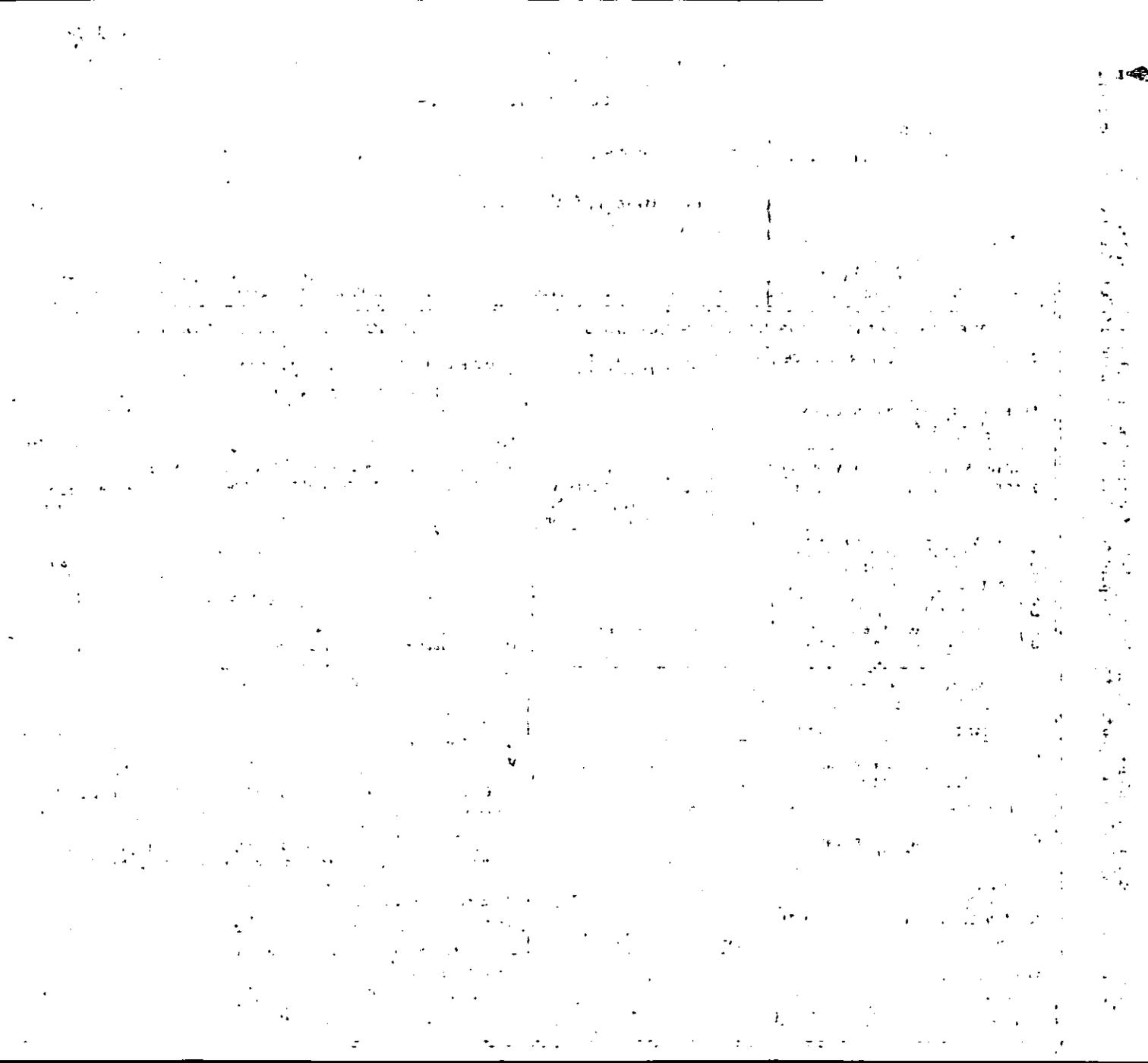
Name of operation Date of
What test confirmed diagnosis? clinical Was there an autopsy? No

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) Herman H. Schneider, M. D.
(Address) Marthasville Mo.

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



MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29217

Registration District No. 759

Primary Registration District No. 6000

Registrar's No.

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town Callaway
(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 Herman A. Steinhilber

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 m

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

7. Birth date of deceased Sept 29, 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 18 min. _____
(If less than one day)

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10/13/41 (b) Irene Rickmers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town Rural, P.O. Foristell
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August Day Thirteenth
year 1941 hour 01 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him/her 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

New Mexico

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

