

S. No. 2
1-1-41
7-5-17-41

FILLED OCT 27 1941

Registration District No. 370

Primary Registration District No. 3429A

Registrar's No. 159

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

1. PLACE OF DEATH:

(a) County Gentry

(b) City or town Darlington *Prok*

(c) Name of hospital or institution: Prok

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution all life (Specify whether years, months or days)

In this community all life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County Gentry *38*

(c) City or town Darlington *0020*

(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 _____

3. (a) PRINT FULL NAME Wallace V. Hines

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7th year 1941 hour 5 minute A. M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Sadie Mae Davis

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

7. Birth date of deceased. Dec. 22 1878

(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 27 1940 to Sept 5 1941

that I last saw him alive on Sept 4 1941 and that death occurred on the date and hour stated above.

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

62 8 15 hr. min.

Immediate cause of death Acute Prostatitis *7 Wks.*

Duration _____

9. Birthplace Gentry Co. Missouri

(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation Labor

Other conditions _____ (Include pregnancy within 3 months of death)

11. Industry or business BY LICENSED EMBALMER

12. Name Wachie Hines

13. Birthplace Unk. Unk.

(City, town, or county) (State or foreign country)

14. Maiden name Unk.

15. Birthplace Unk. Unk.

(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

I hereby certify that the body whose name is recorded on this certificate was embalmed by _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Chas. Hines

(b) Address Darlington, Mo.

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof 9/8/41

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

(c) Place: burial or cremation Rouse

(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? _____

18. (a) Signature of funeral director W. H. Hines

(b) Address Darlington, Mo.

(Specify type of place)

While at work? _____ (e) Means of injury _____

THE SIGNATURE OF THE LICENSED EMBALMER IS REQUIRED IN ALL CASES

W. H. Hines

19. (a) Sept 29 (b) Mattie Seard

(Date received local registrar) (Registrar's signature)

Address of licensed embalmer Darlington, Mo.

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Clifford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany Mo

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. **34885**

Registration District No. **376**

Primary Registration District No. **5429A**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Gentry**
(b) City or town **Washington**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **cooper**
(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 **Mo** (b) County **Gentry**
(c) City or town **Washington Mo**
(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.....

3. (a) PRINT FULL NAME **Wallace V. Hines**

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..... **Widowed**

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

7. Birth date of deceased **Dec 22 1875**
(Month) (Day) (Year)

8. AGE: Years **62** Months **8** Days **15** If less than one day 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.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) **Sept 29-1941 Mathis David**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** Day **29** Year **1941** hour..... minute..... M.

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

Immediate cause of death.....

Acute Prostatitis! 8 Weeks
Due to **G.P. Infection**
of long standing.

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 **Charles A. Williams MD**) (M. D. or other.....)

Address **Gentry Mo** Date signed **Dec 18**

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE

