

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35103

State File No.

HEU NOV 13 1942

Registration District No. 377

Primary Registration District No. 6276

Registrar's No.

1. PLACE OF DEATH:

(a) County Worth
(b) City or town (Rural) Sheridan, Mo.
(c) Name of hospital or institution:
Rural Union Twp
(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 Worth
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1/2 mile E 2 miles S of Sheridan
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME NELLIE HINES

3. (b) If veteran, _____ 3. (c) Social Security
name war _____ No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married,
1 divorced married
6. (b) Name of husband or wife HOMER 6. (c) Age of husband or wife if
A. Hines alive 72 years
7. Birth date of deceased Dec 11 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 9 15 hr. min.

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

10. Usual occupation housewife

11. Industry or business Farmer

12. Name Francis Marion West
13. Birthplace Ohio 1
(City, town, or county) (State or foreign country)
14. Maiden name Martha Kibler
15. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

16. (a) Informant Homer A. Hines
(b) Address Sheridan Missouri
17. (a) Burial (b) Date thereof Sept. 28, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sheridan cemetery
18. (a) Signature of funeral director John Andrews
(b) Address Grant City Mo
19. (a) Oct 10 - 1942 (b) Armed Schadden
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Sept. 15,
1942 to Sept 26, 19 42
that I last saw him _____ alive on _____, 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Bronchial Pneumonia 2 wks
Due to _____
Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration

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 Clutter Real
Address Grant City 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.....

John Andrews Jr. Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No..... *4211*

P. O. Address..... *Grant City 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.