. 2
4-41
-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6240

FILED MAR 16 1943

Registration District No. 2 [illegible]

Primary Registration District No. 5404

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Kennett, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin 35 0

(c) City or town Kennett - (Rural) 0
(If outside city or town limits, write "RURAL")

(d) Street No. 3 Miles East on Highway 84
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Sharion Jolene Kinnard

3. (b) If veteran, name war

3. (c) Social Security No. no

4. Sex F

5. Color or race W

6. (a) Single, ~~widowed, married,~~ divorced S 0

6. (b) Name of husband or wife

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

7. Birth date of deceased February (Month) 5, (Day) 1943 (Year)

8. AGE: Years | Months | Days 7 | If less than one day hr. 0 min.

9. Birthplace Kennett, (Dunklin Co) (City, town, or county) Missouri (State or foreign country)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Oscar L. Kinnard
13. Birthplace (City, town, or county) Arkansas (State or foreign country)

MOTHER
14. Maiden name Catherine Goldsmith
15. Birthplace Greenway (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Oscar L. Kinnard
(b) Address Route 2 - Kennett, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Gregory Cemetery

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

19. (a) 3-4-43 (Date received local registrar) (b) Mrs. Murt Blankenship (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12
year 1943 hour 3 minute 45 A.M.

21. I hereby certify that I attended the deceased from Feb-5, 1943, to Feb 12, 1943
that I last saw her alive on 2/12/43, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia — Duration 24 hrs

Due to Premature birth

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

159

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) DO

Address Holcomb Date signed 2/15/43

901

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 343-29
Date Filed 3-8-43

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 This Body Was Not Embal

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.

No. 2B
8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 286 Primary Registration District No. (5404) Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Kennett rural
(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)

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

3. (a) PRINT FULL NAME Sharon Jolene Kinnard

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. (Month) 5 (Day) 1892 (Year)

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

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2 year 1943 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
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)

(b) 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 (M. D. or other)

Address Date signed

6240