

No. 1-4
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **13512**
Registrar's No. **108**

FD MAY 11 1943

Registration District No. _____

Primary Registration District No. **40021**

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

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Brushers

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 85 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair

(c) City or town Brushers Mo.
(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 _____

3. (a) PRINT FULL NAME JAMES HINES

(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 25
year 1943 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from APRIL
1 1943 to APRIL 24 1943
that I last saw him alive on APRIL 24 1943
and that death occurred on the date and hour stated above.

4. Sex M. 5. Color or race W.

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

6. (b) Name of husband or wife Marie Hines 6. (c) Age of husband or wife if alive _____ years
(Month) (Day) (Year)

7. Birth date of deceased Jan. 9 1858
(Month) (Day) (Year)

Immediate cause of death Failure of Heart

Due to senility

Due to _____

Other conditions asthma
(Include pregnancy within 8 months of death)

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>3</u>	<u>16</u>	hr. _____ min.

Major findings: NONE

Of operations _____

Of autopsy NO

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Live stock clipper

11. Industry or business same

MOTHER FATHER

12. Name Valentine Hury

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

14. Maiden name Mary Bryant

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

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

(a) Accident, suicide, or homicide (specify) NO

(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 2

23. Signature N.E. Cornstable (M.-D.-or other) DO.
Address Brushers, Mo. Date signed 4/26-43

16. (a) Informant Mrs S.R. Dunham
(b) Address Kirkville, Mo.

17. (a) Burial (b) Date thereof Apr. 27-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La Plata, Mo.

18. (a) Signature of funeral director Fred R. Eschig
(b) Address Brushers, Mo.

19. (a) 4/26/43 (b) Mr. J.W. Wagner
(Date received local registrar) (Registrar's signature)

114 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 5-43-820

Date Filed MAY 10 1943

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 Foster P. Easley

Licensed Embalmer No. 1146

P. O. Address Broken, 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

135-12
State File No. _____
Registrar's No. 108

Registration District No. 1

Primary Registration District No. 4002

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Brashear
(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) 85 yrs

3. (a) PRINT FULL NAME James 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 m

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

7. Birth date of deceased Jan 9 - 185
(Month) (Day) (Year)

8. AGE: Years 92 Months 3 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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) _____ (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair
(c) City or town Brashear
(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 2 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her live on _____ 19____; and that death occurred on the date and hour stated above. (Immediate cause of death)

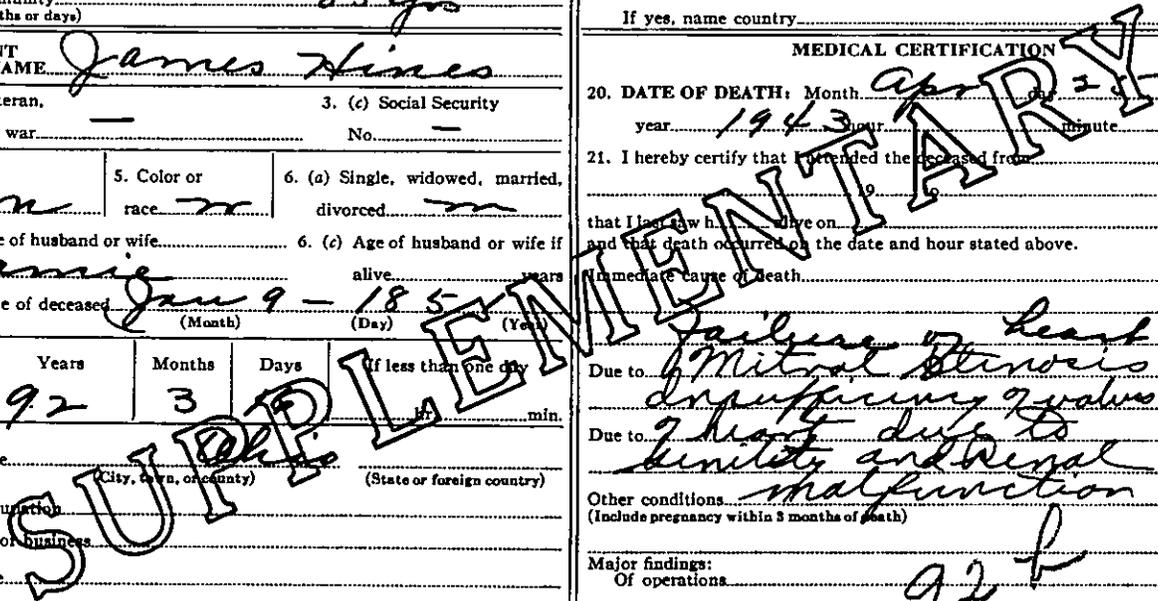
Failure of heart
Due to Mitral stenosis
insufficiency valves
Due to heart due to
arterial and venal
Other conditions malfunction
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
92 f

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 H.E. Constable (M. D. or other) DO.
Address Brashear Mo Date signed _____



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

