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5-17-39  
X32873

24301

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

AUG 10 1943

Registration District No. 34

Primary Registration District No. 5117

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Boone

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

(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 \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

(d) Street No. H. Miles N. E. of Ashland Mo.  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charity Hinschaw

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
year 1943 hour 11 minute 15 AM.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Fernando Hinschaw

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

7. Birth date of deceased June 5 1865  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1 1942 to July 23 1943  
that I last saw him alive on July 23 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 1 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death carcinoma of mouth

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace Indiana 1  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name John Shouse

13. Birthplace Indiana 1  
(City, town, or county) (State or foreign country)

14. Maiden name Lucinda Brown

15. Birthplace Indiana 1  
(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) \_\_\_\_\_

(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

16. (a) Informant Stella M. Swartz

(b) Address Ashland Mo.

17. (a) Burial  
(Burial, cremation, or removal) (b) Date thereof 7 24 1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Columbia Mo.

18. (a) Signature of funeral director W. L. Burnett

(b) Address Ashland Mo.

19. (a) July 27 1943 (b) Mrs. Alice Estes  
(Date received local registrar) (Registrar's signature)

23. Signature H. B. Fryer (M. D. or other) \_\_\_\_\_  
Address Ashland Mo. Date signed 7-24-43

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

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**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 W<sup>MA</sup> C. T. Burnett

Licensed Embalmer No. 3564

P. O. Address Ashtland Md

**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.**