

V. S. No. 2
FORM-2-43
Revised 5-17-68

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27442
Registrar's No. 3503

FILED AUG 21 1943

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
In this community as above
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Louis Pinkepank
(b) If veteran, name war no
(c) Social Security No. none

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced unk.
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 46 Months _____ Days _____
If less than one day _____ hr. _____ min.

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

10. Usual occupation unknown

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant R. C. Carter
(b) Address Sweet Springs, Mo.

17. (a) removal (b) Date thereof 8-12-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sweet Springs, Missouri

18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 8-13-43 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 97
(c) City or town Sweet Springs
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 11th
year 1943 hour 11:20 minute P. M.
21. I hereby certify that I attended the deceased from July 31
1943 to Aug 11 1943
that I last saw him alive on Aug 11 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Professional
Obstruction
Due to Cornway throm-
bosis
Due to _____
Other conditions (include pregnancy within 3 months of death) 122

Major findings: Intestinal
Of operations Obstruction
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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
23. Signature Paul F. Hunt (M. D.)
Address 1032 17th St. Bldg. Date signed 8-12-43

Either Dr. Claude or Dr. Paul Hunt

MAY 24 1945

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..... *J. Blair Sheppard*
Licensed Embalmer No..... *4179*
P. O. Address..... *J. C. No.*

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.