

No. 2
5-17-39
X36671

FILED NOV 24 1944
Registration District No. 752

Primary Registration District No. 5575

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Grand Washington Mo

(c) Name of hospital or institution:
8112 Wayne
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether 1)

In this community 33 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴³

(c) City or town Kansas City ⁰
(If outside city or town limits, write "RURAL") ⁰

(d) Street No. 8112 Wayne
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Charles F. Hinds

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race Wh

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Retta

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Nov 22 1881
(Month) (Day) (Year)

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

62 11 11 hr. min.

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

10. Usual occupation Clerk

11. Industry or business Railway Express Co.

12. Name Finley Hinds

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

14. Maiden name Sarah Matcette

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

16. (a) Informant Welma Craig

(b) Address 8112 Wayne

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-44
(Month) (Day) (Year)

(c) Place: burial or cremation Mount Moriah

18. (a) Signature of funeral director J. P. Davis Funeral Home

(b) Address 1001 Mo

19. (a) 4/15/44 (Date received local registrar) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7
year 1944 hour 3 minute A M.

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

Immediate cause of death Coronary Arteriosclerosis

Due to 94a

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations _____

Of autopsy See Above

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 A. E. [Signature] (M. D. or other) [Signature]
Date signed 11/3/44

1152

OCT 1 1948

DEC 12 1944

DEC 4 1944

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 _____
Licensed Embalmer No. 3110
P. O. Address _____

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.

Registration District No. W 4

Primary Registration District No. 15579

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Normal Washington
(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

3. (a) PRINT FULL NAME Charles F. Heide

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 _____

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

7. Birth date of deceased Nov 22 1888
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days _____
If less than one day

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

10. Usual occupation _____

MOTHER FATHER

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day _____
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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