

FILED DEC 13 1944

Registration District No. 6276274 Primary Registration District No. 374450 Registrar's No.

1. PLACE OF DEATH:

- (a) County North
(b) City or town Sherridan, Mo.
(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 1 (Specify whether

In this community 48 yrs. years, months or days)

3. (a) PRINT FULL NAME

Samuel Franklin Kinard

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 married

6. (b) Name of husband or wife Mrs. J. Kinard 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Aug 1862 (Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 8 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business:

12. Name John Kinard

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

14. Maiden name Unknown

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

16. (a) Informant Laura Dalrymple

- (b) Address Manassas City, Mo.

17. (a) Burial (b) Date thereof 9-11-44 (Month) (Day) (Year)

- (c) Place: burial or cremation Sherridan Chm.

18. (a) Signature of funeral director John C. Dwyer

- (b) Address Sherridan City, Mo.

19. (a) Oct 15 - 1944 (b) Arthur Stalden (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County North

- (c) City or town Sherridan, Mo. (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 9 day 9 year 1944 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from 8-28 to 9-8 1944

that I last saw him alive on 9-8 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration Duration 5 yrs

of heart

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)

- (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 Arthur Stalden (M. D. or other)

Address Sherridan City, Mo. Date signed 9-15-44

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

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.....

Arch C. Dwyer

Licensed Embalmer No. *3252*

P. O. Address.....

Grant City, 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.