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7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16444**

FILED JUN 14 1945

Primary Registration District No. **20075143**

Registrar's No. **148**

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

1. PLACE OF DEATH: **Butler**

(a) County **Butler**

(b) City or town **Poplar-Bluff**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Poplar Bluff Rt. #5**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **33 Years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Butler**

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

(d) Street No. **Route # 5**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Diana Kingery**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **23** year **1945** hour **6** minute **A** a.m.

4. Sex **F** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Walter Kingery** 6. (c) Age of husband or wife if alive **87** years

7. Birth date of deceased **Feb 12 1864**
(Month) (Day) (Year)

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

8. AGE: Years **81** Months **32** Days **11** If less than one day hr. min.

Immediate cause of death **Cardiac Asthma**

Duration **unknown**

9. Birthplace **Cumberland Co. Ill.**
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation **Housewife**

Other conditions **nd**
(Include pregnancy within 3 months of death)

11. Industry or business _____

Major findings: Of operations **950**

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name **John Warner**

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

14. Maiden name **Mary Jane Estas**

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

16. (a) Informant **Otis Kingery**

(b) Address **Poplar Bluff Rt. #5**

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? _____

17. (a) **Burial** (b) Date thereof **5/26/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Cemetery**

18. (a) Signature of funeral director **Greer Croy & Fitch**

(b) Address **Poplar Bluff, Mo.**

While at work? _____ (Specify type of place) (c) Means of injury **3**

23. Signature **Howard W. Spencer** (M. Coroner)
Address **Poplar Bluff, Mo.** Date signed **5/26/45**

19. (a) **5/26/45** (b) **Belle Turner**
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Office No.

District File Number 645-83

Date Filed 6-12-45

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 Wallace N. Fitch

Licensed Embalmer No. 3859

P. O. Address Poplar Bluff, 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.