

Registration District No. 187

Primary Registration District No. 3040

State File No. _____

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Livingston
 (b) City or town Chillicothe
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Chillicothe Hospital 5
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 (Specify whether
 In this community 55 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Livingston 59
 (c) City or town Chillicothe 1
 (If outside city or town limits, write "RURAL") 2
 (d) Street No. 423 Clay Street
 (If rural, give location)
 (e) Citizen of foreign country? No 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Rosa Arlena Kinser

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lon Kinser 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased March 11th. 1890
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>1</u>	<u>5</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Peter Parkey

13. Birthplace Unknown France 3
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Lon Kinser

(b) Address Chillicothe, Missouri

17. (a) Burial (b) Date thereof 4-18-'45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brassfield Cemetery

18. (a) Signature of funeral director Norman Funeral Home

(b) Address Chillicothe, Missouri

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th.
 year 1945 hour 6: minute 00 A.M.

21. I hereby certify that I attended the deceased from March 2
 1945 to April 16 1945
 that I last saw her alive on April 15 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus & bladder 1 year
 Duration

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 6 months of death)

Major findings:
 Of operations _____

Of autopsy H&B

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?

(Specify type of place)
 While at work _____ (e) Means of injury _____

23. Signature R. M. Brennan (M. D. or _____)

Address Chillicothe, Mo Date signed 4/17/45

WRITE PLAINLY—USE UNFADING INK

MOTHER FATHER

458

RECEIVED
District Health Officer No. 11
Date Filed
District Health Number

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 Elmer Thomas, Registered Apprentice No. _____ working under my personal supervision.

X X X

Signed Elmer Thomas
Licensed Embalmer No. 2640

P. O. Address Chillicothe, 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.

5/11/11

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(b) City or town Chillicothe
(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 Rosa A. Kaiser

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 _____

7. Birth date of deceased ma (Month) 11 (Day) 1945 (Year)

8. AGE: Years 55 Months 5 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 17 (Date received local registrar) (b) L. H. E. L. A. Curry (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 April year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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)

Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

17410