S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 21 1945

Registration District No. 1

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30009

Primary Registration District No. 3000

Registrar's No. 195

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Laughlin Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days)
In this community 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County Van Buren 999
(c) City or town Keosauqua Ia 13
(If outside city or town limits, write "RURAL")
(d) Street No. — 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME Mrs. Lucinda J. Rinabarger
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Married 1
6. (b) Name of husband or wife Carrol L. Rinabarger
6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased Aug (Month) 2 (Day) 1902 (Year)

8. AGE: Years 43 | Months 1 | Days 0 | If less than one day ___ hr. ___ min.

9. Birthplace Birmingham Iowa 1 (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Labor
MOTHER FATHER
12. Name Stephen Asa Jones
13. Birthplace Birmingham Ia 1 (City, town, or county) (State or foreign country)
14. Maiden name Effie A. Lee
15. Birthplace Glasgow Ia 1 (City, town, or county) (State or foreign country)
16. (a) Informant Carrol L. Rinabarger
(b) Address Keosauqua Ia
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Fellows Cemetery
18. (a) Signature of funeral director H A Burnett
(b) Address Keosauqua Ia
19. (a) 9-2-45 (Date received local registrar) (b) Mrs. F. Wayne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2 year 1945 hour 6 minute 25 A.M.
21. I hereby certify that I attended the deceased from Aug 22, 1945, to Sept 2, 1945; that I last saw her alive on Sept 2, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Sigmoid
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
469

Major findings: Of operations Adenocarcinoma Recto-sigmoid junction
Of autopsy

Duration

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 Earl Laughlin Jr (M. D. or other) Do
Address Kirksville Mo Date signed 9-2-45

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-45-1454
Date Filed SEP 19 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 myself H. A. Burnett, ~~Registered Apprentice No.~~ ~~working under my personal supervision.~~

Signed H. A. Burnett

Licensed Embalmer No. mo. 2668

P. O. Address Keosauqua Ia

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.