DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 22 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31105

State File No.

Registration District No. 254 Primary Registration District No. 5867 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Thayer Rural Thayer Twsp.
(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 28 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75

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

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John A. Pingleton

3. (b) If veteran, name war --

3. (c) Social Security No. 497-18-2848

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Issie Combs

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased November (Month) 9 (Day) 1890 (Year)

8. AGE:

Years	Months	Days	If less than one day
54	8	11	hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Jeff Pingleton
13. Birthplace (City, town, or county) Tennessee / (State or foreign country)

MOTHER
14. Maiden name Paralee Tillman
15. Birthplace (City, town, or county) Tennessee / (State or foreign country)

16. (a) Informant Grover Pingleton
(b) Address Thayer, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/45 (Month) (Day) (Year)
(c) Place: burial or cremation Bailey Cem.

18. (a) Signature of funeral director Leo Carr
(b) Address Thayer, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1945 hour 8 minute 15 P.M.

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

Immediate cause of death Acute Mononucleosis

Due to Chronic Prostatitis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 137b

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 C W Cooper (M. D. or other) M.D.

Address Thayer Mo Date signed 9-17-45

1483

(Licensed Embalmer's Statement on Reverse Side)

Hull + Cooper.

RECEIVED
District Health Officer No. 5,
District File Number 945-776
Date Filed 9-21-45

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 .....

Licensed Embalmer No. .....

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.

2B
3-45
43883

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

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BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 254 Primary Registration District No. ( ) Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town "Rural" Thayer Twp
(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)

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

3. (a) PRINT FULL NAME John A. Pingleton

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 (Month) 9 (Day) 1899 (Year)

8. AGE: Years 54 Months 8 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) Mary V. Hall (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 20
year 1945 hour 8 minute M.

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

	Duration
Immediate cause of death	
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.

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(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

SUPPLEMENTARY

31105