

FILED NOV 16 1945

Registration District No. 4550

Primary Registration District No. 4550

Registrar's No.

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Sheridan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 75 yrs.
(Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME

Walter K. Kinnemiller

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MO

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary Jane Kinnemiller

6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased avg.

20 1863
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 11
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Jacob Kinnemiller

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

14. Maiden name Clara J. Kinnemiller

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

16. (a) Informant Jessie Kinnemiller

(b) Address Sheridan, Mo.

17. (a) Burial (b) Date thereof 10-3-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheridan, Mo.

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

(b) Address Grant City, Mo.

19. (a) Oct 13, 1945 (b) Leta E. Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Worth
(c) City or town Sheridan
(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)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 1
year 1945 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from 9-28-45
1945, to 10-1 1945
that I last saw him alive on Sept. 30 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Duration 3 days

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) (c) Means of injury

23. Signature W. C. Dwyer (M. D. or other)
Address Grant City, Mo. Date signed Oct 13, 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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Arch C. Dunfee

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.