

12-45  
17-39

X47070

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

DEPARTMENT OF COMMERCE

THE STATE BOARD OF HEALTH OF MISSOURI

**FILED** OCT 7 1946

# STANDARD CERTIFICATE OF DEATH

30900

State File No. \_\_\_\_\_

Registration District No. 385

Primary Registration District No. 3039

Registrar's No. 93

1. PLACE OF DEATH

(a) County Lin

(b) City or town Marceline  
(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 years, months or days)

In this community 52 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lin 58

(c) City or town Marceline 2  
(If outside city or town limits, write "RURAL")

(d) Street No. 723 N. Kansas Ave. 1  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ida Bell Kinnear

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1946 hour 8 minute 30 p.m.

4. Sex Female 5. Color or race white

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

(b) Name of husband or wife John Kinnear

6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased May 1946  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 9, 1946, to Sept 17, 1946; that I last saw her alive on Sept 17, 1946; and that death occurred on the date and hour stated above.

8. AGE: Years 80 Months 4 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation housewife

Immediate cause of death shock Duration 3 hrs.

Due to gastric hemorrhage 2 da

Due to probable gastric cancer ? 1 yr.

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name James Boyd Hoxford

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

14. Maiden name Mary Antishia Powell

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

16. (a) Informant Dale Burch

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Sept 20 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olivet

18. (a) Signature of funeral director James McLaughlin

(b) Address Marceline Mo

19. (a) 9/27/46 (b) Ed Shelton  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_

Of autopsy HCB

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) (e) Means of injury 0

23. Signature Philip D. Ottman (M. D. or other) M.D.  
Address 101 S. Kansas Ave., Marceline, Mo. Date signed Sept 18, 46

OCT 9 1940

---

---

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 *Blanche M. Langhlin*

Licensed Embalmer No. *1909*

P. O. Address *Marceline 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.**