

No. 2
 18-43
 17-5
 37823

FILED NOV 7 1946
 Registration District No. 171

Primary Registration District No. 4268

State File No. _____

Registrar's No. 1-

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Mayview, Mo.
(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 All his life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 54
 (c) City or town Mayview, Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16th 1946
 year 1946 hour 10:45 minute 1 M.

21. I hereby certify that I attended the deceased from Sept. 1st - 1946 to Sept 16th 1946
 that I last saw him alive on Sept. 16th 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation from pressure on trachea. Duration _____

Due to general carcinoma

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations None.
 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) (e) Means of injury 1

23. Signature Geo B. Willis, M.D. (M. D. or other)
 Address Mayview, Mo. Date signed 9/16/46

3. (a) PRINT FULL NAME Robert F. Kincheloe

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 12 1882
(Month) (Day) (Year)

8. AGE: Years 64 Months -- Days 4
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Stockman

11. Industry or business _____

12. Name C. W. Kincheloe

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

14. Maiden name Fannie Dalton

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

16. (a) Informant Mon Tracy

(b) Address Mayview, Mo.

17. (a) Burial (b) Date thereof 9/17/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hebron

18. (a) Signature of funeral director W. S. Slade

(b) Address Higginville, Mo.

19. (a) 9-21-46 (b) Seth Drummond
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No.

District File Number

Date Filed 1-2-46

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 *Forrest R. Rickhal*

Licensed Embalmer No. *4284*

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.

Registration District No. 171

Primary Registration District No. 4268

1. PLACE OF DEATH:

(a) County Safayette
(b) City or town mayview
(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 Robert J. Kirchel

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 s

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept (Month) 12 (Day) 1946 (Year)

8. AGE: Years 64 Months _____ Days _____ 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) Sept. 21-46 (b) Robert J. Kirchel (Registrar's signature)
(D) received local registrar (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 _____ day _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ 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)

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) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

- 34018