No. 2
1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 8 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26895

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 1053

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 week (Specify whether years, months or days)
In this community: 1 week

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Andrew
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: R.R.#2 Savannah, Mo.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Henry Sinke
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Cora Sinke
6. (c) Age of husband or wife if alive: 67 years
7. Birth date of deceased: February (Month) 3 (Day) 1866 (Year)
8. AGE: Years 81 | Months 6 | Days 28 | If less than one day: hr. min.
9. Birthplace: Wathena (City, town, or county) Kansas (State or foreign country)
10. Usual occupation: Retired Farmer
11. Industry or business:
12. Name (Father): Frederick Sinke
13. Birthplace (Father): Unknown (City, town, or county) Germany (State or foreign country)
14. Maiden name (Mother): Fredericka Feichtel
15. Birthplace (Mother): Unknown (City, town, or county) Germany (State or foreign country)
16. (a) Informant: Mrs. Cora Sinke
(b) Address: R.F.D. #2 Savannah, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 4, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park Cemetery
18. (a) Signature of funeral director: Walter Meierhoffer
(b) Address: 1946 Colhoun St., St. Joseph, Mo.
19. (a) 9-3-47 (Date received by local registrar) (b) E. L. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 1st year 1947 hour 2 minute 30 P.M.
21. I hereby certify that I attended the deceased from Aug. 20 19 47 to Sept. 1 19 47 and that death occurred on the date and hour stated above.
Immediate cause of death: Trifacial Neuralgia — Duration: 6 mos
Due to: Pneumonia — 2 days
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy:

PHYSICIAN — Underline the cause of death that should be tabulated.

SUPPLEMENTARY INFORMATION REQUESTED

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: (M. D. or other)
Address: St. Joseph, Mo. Date signed: 9-2-47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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

NOV 24 1942

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 Albert E. Harrington

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, 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.

No. 2B
M—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 10V-3

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St Joseph
(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

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: Henry Sinke

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: Jul. 3 (Month) (Day) 1 (Year)

8. AGE: Years 81 Months 6 Days 8 If less than one day hr. min.

9. Birthplace: (City, town, or county) Kansas (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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 1 Year 1947 Hour 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.

Immediate cause of death — Duration
Trifacial neuralgia

Due to: Bilateral lobar pneumonia

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 10 8

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: P. A. Knepper, MD (M. D. or other)
Address: St. Joseph, Mo. Date signed

SUPPLEMENTARY

26895