No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 27 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

34203

State File No.

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 885

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: O'Reilly Veterans Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mo. 24 days (Specify whether years, months or days)
In this community Since hospitalized

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Sedgwick
(c) City or town Wichita
(If outside city or town limits, write "RURAL")
(d) Street No. 1248 S. Main
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME HINSHAW, Donald Lee
3. (b) If veteran, name war One
3. (c) Social Security No. 511 07 8225

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased 3/10/01 (Month) (Day) (Year)

8. AGE: Years 46 | Months 0 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Jet Oklahoma (City, town, or county) (State or foreign country)
10. Usual occupation None Listed
11. Industry or business unknown

MOTHER FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) unknown (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) unknown (State or foreign country)

16. (a) Informant Correspondence Records
(b) Address O'Reilly VA Hospital
17. (a) Personal (Burial, cremation, or removal) (b) Date thereof 10-8-47 (Month) (Day) (Year)
(c) Place: burial or cremation Wichita, Kans.
18. (a) Signature of funeral director German-Schopf Funeral Home
(b) Address Springfield Mo
19. (a) 10-13-47 (Date received local registrar) (b) W.S. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8
year 1947 hour 9 minute 45 A.M.
21. I hereby certify that I attended the deceased from 5/14/47, 19..., to 10/8/47, 19...; that I last saw him alive on October 8, 1947, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis, pulmonary, chronic far advanced, active	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy	

PHYSICIAN
Underline the cause of 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? (Yes or No) Means of injury

23. Signature PAUL L. EISELE (M. D. or XXX)
Address O'Reilly VA Hospital Date signed 10/8/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 L. Dodie Forman ....

Licensed Embalmer No. 3177 ....

P. O. Address Springfield 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.