

FILED DEC 3 1947

Registration District No. _____

Primary Registration District No. **4078**

Registrar's No. **81**

1. PLACE OF DEATH:

(a) County **Cape Girardeau**
 (b) City or town **Delta**
 (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 _____
 In this community **11 years**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Scott** **100**
 (c) City or town **Delta**
 (d) Street No. **Welsh Twp.**
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Samuel R. Kynion**

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 **Widower**
 6. (b) Name of husband or wife **Sarah Kitty Ann Kynion**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **July 22 1861**
 (Month) (Day) (Year)

8. AGE: Years **86** Months **3** Days **29**
 If less than one day _____ hr. _____ min.

9. Birthplace **Near Delta Mo**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
 12. Name **Rube Kynion**
 13. Birthplace **Unknown**
 14. Maiden name **Unknown**
 15. Birthplace **Unknown**

16. (a) Informant **Mr. Susan Berneman**
 (b) Address **Delta**

17. (a) **Burial** (b) Date thereof **Nov 23, 1947**
 (c) Place: burial or cremation **Fairview Cape Co. Mo**

18. (a) Signature of funeral director **Displinghaff Funeral Home**
 (b) Address **Chaffee**

19. (a) **11-25-47** (b) **D. S. Tubior**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV 21** 1947 day _____
 year _____ hour **6** minute **30 P** M.

21. I hereby certify that I attended the deceased from **Oct 2** 1947 to **Nov 21** 1947
 that I last saw him alive on **Nov 20** 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death **influenza**
Old age
 Due to **weakness of heart muscle**

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

Major findings:

Of operations **33 P**
 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? _____
 (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 **W. W. Bayne** (M. D. or other) **MD**
 Address **Allenville Mo** Date signed **Nov 21-47**

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

RECEIVED

Health Officer No. 4

File Number 1247-1516

12-2-47

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

Jack J. Burnett, Registered Apprentice No. 516
working under my personal supervision.

Signed Mamie Buepling Huff

Licensed Embalmer No. 3242

P. O. Address Chaffee, 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.