

Registration District No. **192**

Primary Registration District No. **4308**

Registrar's No. **35**

1. PLACE OF DEATH:

(a) County **Mo. Souders**

(b) City or town **Moel, Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **None**
(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 **None**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Mo. Souders**

(c) City or town _____
(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 _____

3. (a) PRINT FULL NAME **Lester E. Hinkle.**

3. (b) If veteran **None** name war _____

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **15th** year **1947** hour **4:50** minute **45** M.

21. I hereby certify that I attended the deceased from **September 23** 19**47**, to **Dec 15** 19**47**, and that I last saw him alive on **Dec 15** 19**47** and that death occurred on the date and hour stated above.

4. Sex **M** race **W**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **M-1**

6. (b) Name of husband or wife **Unknown**

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

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

Immediate cause of death **Cerebral hemorrhage** Duration **12 hrs**

Due to **arteriosclerosis** **6 yrs**

Due to _____

8. AGE: Years **75** Months **-** Days **-** If less than one day _____ hr. _____ min.

9. Birthplace **Unknown** (City, town or county) _____ (State or foreign country) **A**

10. Usual occupation **Retired**

11. Industry or business **Retired**

12. Name **Unknown**

13. Birthplace **"** (City, town or county) _____ (State or foreign country) **G**

14. Maiden name **Unknown**

15. Birthplace **"** (City, town or county) _____ (State or foreign country) **G**

16. (a) Informant **Hotel Records**

(b) Address **Moel, Mo.**

17. (a) **Removal** (Burial, cremation, or removal)

(b) Date thereof **12-17-47** (Month) (Day) (Year)

(c) Place: burial or cremation **Garrettsville, Ohio**

18. (a) Signature of funeral director **W. H. ...**

(b) Address **Garrettsville, Ohio**

19. (a) **1-16-48** (Date received local registrar)

(b) **Virginia Buck** (Registrar's signature)

Other conditions (include pregnancy within months of death) **Endarteritis, nephritis**

Major findings: _____

Of operations _____

Of autopsy **GB**

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? _____ (e) Means of injury **2**

23. Signature **SP Fontaine** D. or other _____

Address **Moel, Mo.** Date signed **Dec 16**

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

MOTHER FATHER

6030

RECEIVED

District Health Officer No. 6;
District File Number 148-85-
Date Filed JAN 14 1948

APR 29 1950

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 me

....., Registered Apprentice No. ✓
working under my personal supervision.

Signed R. E. Cheston

Licensed Embalmer No. 9813

P. O. Address Anderson 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.