

FILED JUN 24 1948

Registration District No. _____

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20110

3041

Primary Registration District No. _____

Registrar's No. 326

1. PLACE OF DEATH:

(a) County Macon
 (b) City or town Macon Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (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 James H. Sinnett
 3. (b) If veteran _____ 3. (c) Social Security No. _____
 name war _____

4. Sex M Color or race W
 5. Color or race _____
 6. (a) Single, widowed, married, divorced 1
 6. (b) Name of husband or wife Mary Sinnett
 6. (c) Age of husband or wife if alive 52 years
 7. Birth date of deceased May 10 1868
 (Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 8
 If less than one day _____ hr. _____ / min.

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

10. Usual occupation Farmer

11. Industry or business Henry Sinnett

12. Name _____

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

14. Maiden name Sarah Witzel

15. Birthplace Ill (City, town, or county) (State or foreign country)

16. (a) Informant Mary E. Sinnett

(b) Address Macon, Mo

17. (a) Burial (b) Date thereof 4-10-48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Salem Cem

18. (a) Signature of funeral director Stephen Gooden

(b) Address Macon, Mo

19. (a) 6/14/48 (b) Ruth McNeely
 (Date received local registrar) (Registrar's signature)

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
 (c) City or town Macon
 (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 April day 2
 year 1948 hour 4 minute 00 A.M.

21. I hereby certify that I attended the deceased from 19-Nov-46 to 2 April 48
 that I last saw him alive on 2 April 48
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Distention
 Duration _____

Due to Acute Stenosis and Regurgitation
 Disruptive Myocarditis

Other conditions family
 (Include pregnancy within 6 months of death)

Major findings: _____

Of operations no

Of autopsy no

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? _____

(e) Means of injury _____

While at work? _____ (Specify type of place)

23. Signature H. E. Quinn (M. D. or other) _____

Address Macon, Mo Date signed 4-27-48

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 6-48-109

Date Filed JUN 22 1948

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 _____

James C. Cleaver

Registered Apprentice No. 515

working under my personal supervision.

Signed *C. L. Stephens*

Licensed Embalmer No. 3057

P. O. Address Macon, 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.

July
326

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 326

1. PLACE OF DEATH:

(a) County macon
(b) City or town macon
(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

James H. Sinnott
3. (b) If veteran name war _____
3. (c) Social Security No. _____

4. Sex m 5. Color of 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 _____

7. Birth date of deceased may 10 20
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
29 10 20 hr. min.

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

10. Usual occupations Farmer

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date 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 1948 hour _____ minute _____ M.

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

that I last saw him _____ alive on _____, 19____;

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

S-20110