

FILED FEB 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 4012 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <b>Atchison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Worth</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rock Port.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sheridan, Mo.,</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <b>HOMER</b>		b. (Middle) <b>HINES</b>	
c. (Last) <b>HINES</b>		4. DATE OF DEATH (Month) <b>1</b> (Day) <b>9</b> (Year) <b>1949</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>11-27-1869</b>	
9. AGE (In years last birthday) <b>79</b>		10. UNDER 1 YEAR (Months) <b>1</b>	
11. UNDER 12 MRS. (Days) <b>12</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Defiance, Mo.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13a. FATHER'S NAME <b>S.F. Hines</b>		13b. MOTHER'S MAIDEN NAME <b>Harriet Stone</b>	
14. NAME OF HUSBAND OR WIFE <b>Margaret Allen West.</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY <b>491-28-0899</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Duane Fox.</b> ADDRESS <b>Rock Port. Missouri</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute general peritonitis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Perforated ulcerating adenocarcinoma of stomach.</b> DUE TO (c) <b>Hepatic insufficiency due to extensive liver metastases.</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>151X</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Rock Port Atchison Mo</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from <b>Nov 10, 1948</b> , to <b>Jan 9, 1949</b> , that I last saw the deceased alive on <b>Jan 9, 1949</b> , and that death occurred at <b>5:30 pm.</b> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <b>[Signature]</b>		23b. ADDRESS <b>Rock Port, Mo.</b>	
23c. DATE SIGNED <b>11 Jan 49</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24b. DATE <b>1-12-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Sheridan Cem.</b>	
24d. LOCATION (City, town, or county) (State) <b>Sheridan, Missouri</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Bartholomew Mortuary</b> ADDRESS <b>Rock Port. Mo.</b>	
DATE REC'D BY LOCAL REG. <b>1-11-49</b>		REGISTRAR'S SIGNATURE <b>Betty Crabtree</b>	

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

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**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

Signed.....  
Student Embalmer

Licensed Embalmer No. ....

P. O. Address.....

**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.