

FILED JUN 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14807**

BIRTH NO. _____ REG. DIST. NO. 31 PRIMARY REG. DIST. NO. 4040 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY Benton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Benton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cole Camp /		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cole Camp Rural Williams Township	
c. LENGTH OF STAY (in this place) 7 years		d. STREET ADDRESS (If rural, give location) 5 Miles South East	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home			

3. NAME OF DECEASED (Type or Print)	a. (First) Henry	b. (Middle) None	c. (Last) Hink	4. DATE OF DEATH (Month) (Day) (Year)
				May 22nd 1949

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4-27-1865	9. AGE (In years last birthday) 84	# UNDER 1 YEAR Months	# UNDER 2 HRS. Hours	# UNDER 2 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A
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13a. FATHER'S NAME Wilken Hink	13b. MOTHER'S MAIDEN NAME Imbush	14. NAME OF HUSBAND OR WIFE Sena Hink
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Sena Hink	ADDRESS Cole Camp Mo
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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		INTERVAL BETWEEN ONSET AND DEATH 334X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Apoplexy DUE TO (c) _____ 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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 4-26, 1949, to 5-22, 1949, that I last saw the deceased alive on 5-20, 1949, and that death occurred at 8:00 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. W. Moreland	23b. ADDRESS RR 2 Cole Camp, Mo	23c. DATE SIGNED 5-23-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-26-1949	24c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran	24d. LOCATION (City, town, or county) (State) Cole Camp Mo
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DATE REC'D BY LOCAL REG. 4-23-49	REGISTRAR'S SIGNATURE E. L. Eckhoff 394	25. FUNERAL DIRECTOR'S SIGNATURE E. L. Eckhoff	ADDRESS Cole Camp Mo
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

8007

RECEIVED

District Health Officer No. 7,

District File Number 4-49-603

Date Filed 5-21-49

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 E. Z. Eubank

Signed _____
Student Embalmer

Licensed Embalmer No. 730

P. O. Address Cole Camp 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.