

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15127

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>3010</u>		Registrar's No. <u>141</u>	
1. PLACE OF DEATH <i>burial</i> a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Bollinger</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Cape Girardeau</u>		c. LENGTH OF STAY (in this place) <u>4 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Cracked Creek</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis</u>				d. STREET ADDRESS (If rural, give location) <u>8 miles North of Integville Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Moses</u> b. (Middle) <u>Sylvester</u> c. (Last) <u>Lincoln</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 9 1949</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept 2/1880</u>	
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u>		IF UNDER 2 HRS. Hours <u>7</u> Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>			11. BIRTHPLACE (State or foreign country) <u>Bollinger Co Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Danil Lincoln</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Masters</u>			14. NAME OF HUSBAND OR WIFE <u>Fannie Lincoln</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charles Lincoln Bessville Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Sigmoid</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>with generalized metastases</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Hypertrophic Arthritis</u> <u>12 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>153X</u> <u>10 yrs</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>12 years</u>				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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 <u>6-6</u> , 19 <u>48</u> , to <u>5-9</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>6-9</u> , 19 <u>49</u> , and that death occurred at <u>2 0</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. S. Schaefer, M.D.</u>				23b. ADDRESS <u>804 1/2 Broadway</u>		23c. DATE SIGNED <u>5-9-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/11/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Plainview</u>		24d. LOCATION (City, town or county) (State) <u>Bollinger Co Mo</u>	
DATE REC'D BY LOCAL REG. <u>5-16-1949</u>		REGISTRAR'S SIGNATURE <u>G. C. Summers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm E Kinder</u>		ADDRESS <u>Suburban</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 4

District File Number 549-687

Filed 5-23-49

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.

Student
Student Embalmer

Signed Gene C. Crawford

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.