

FILED OCT 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32415

BIRTH NO. _____ REG. DIST. NO. 359 PRIMARY REG. DIST. NO. 6219 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY VERNON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL Drywood		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Drywood	
c. LENGTH OF STAY (in this place) 30 YRS		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) SOLOMON MANON HINKLE			4. DATE OF DEATH (Month) (Day) (Year) Sept. 24-50		
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH: MARCH 15 1873		9. AGE (In years last birthday) 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MONROE CO. IOWA	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME HAMILTON M. HINKLE	13b. MOTHER'S MAIDEN NAME ROENA HINKLE	14. NAME OF HUSBAND OR WIFE CORABELL LONG
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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 Bernard Hinkle ADDRESS Sheldon
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive heart disease		5 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		443x
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial asthma		10 yrs	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	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 **7-1**, 19**45**, to **9-24**, 19**50**, that I last saw the deceased alive on **6-24**, 19**50**, and that death occurred at **1:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) F. L. Martin	23b. ADDRESS Wesley MO	23c. DATE SIGNED 9-25-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 26-50	24c. NAME OF CEMETERY OR CREMATORY Sheldon	24d. LOCATION (City, town, or county) (State) Sheldon Mo.
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DATE REC'D BY LOCAL REG. Sept 30 1950	REGISTRAR'S SIGNATURE Mrs. Ruth Faith	FUNERAL DIRECTOR'S SIGNATURE S. Bernard ADDRESS Benny Sheldon Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48
80

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED OCT 3 1950

Dist. File 1050-2039

Date Filed 10-3-50

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 L. Bernard Bump

Licensed Embalmer No. 4161

P. O. Address Sheldon, 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.