S. No. 300
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FILED JAN 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40379

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 2046

39 6 0

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

1. PLACE OF DEATH
a. COUNTY GREENE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Springfield
c. LENGTH OF STAY (in this place) 12 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Burge Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY Greene 20
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Springfield, Rural, S. Campbell Twp
d. STREET ADDRESS (If rural, give location) R.R #9.

3. NAME OF DECEASED (Type or Print)
a. (First) Grace
b. (Middle) Belle
c. (Last) Kinser.

4. DATE OF DEATH (Month) 12 (Day) 25 (Year) 50

5. SEX f. 1
6. COLOR OR RACE W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M. 1
8. DATE OF BIRTH Dec. 25-1888.
9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR Months | Days — IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Mo. U
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Benjamin Fulton
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND ~~OR WIFE~~ Thomas Albert Kinser.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT'S SIGNATURE OR NAME Clifford Kinser (son) ADDRESS 1321 N. Campbell

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) Hemorrhage, cerebral — INTERVAL BETWEEN ONSET AND DEATH 21 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 331A

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) Greene, Missouri

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12,24,50 *19*___, *to* 12,25,50, *19*___, *that I last saw the deceased alive on* 12,24,50, *19*___, *and that death occurred at* 1:A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Dmusick MD U
23b. ADDRESS Springfield, Missouri
23c. DATE SIGNED 12,27,50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-27-50
24c. NAME OF CEMETERY OR CREMATORY Hazelwood
24d. LOCATION (City, town, or county) (State) Springfield, Mo

DATE REC'D BY LOCAL REG. 12-27-50
REGISTRAR'S SIGNATURE W E Handley MD
25. FUNERAL DIRECTOR'S SIGNATURE Kelley Parrell Bergman Rogers ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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 Don Ferrell, Student Embalmer No. 397, working under my personal supervision.

Student Don L. Ferrell
Student Embalmer

Signed K. K. Kelley
Licensed Embalmer No. 3334.
P. O. Address Fordland 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.