

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18962**

FILED JUN 9 1953

BIRTH NO. **30952** REG. DIST. NO. **282** PRIMARY REG. DIST. NO. **5968** Registrar's No. **68**

1. PLACE OF DEATH a. COUNTY Polk		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, write RURAL and give township) Hallway Benton Sup 2		c. CITY (If outside corporate limits, write RURAL and give township) Hallway Benton Sup 2	
c. LENGTH OF STAY (In this place) 4 hrs		d. STREET ADDRESS (If rural, give location) 4 miles N.E. of Fairplay	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4 Miles N.E. of Hallway			

3. NAME OF DECEASED (First) (Middle) (Last) Carolyn Sue Hinkle		4. DATE OF DEATH (Month) (Day) (Year) May 25 1953	
5. SEX F	6. COLOR OR RACE wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH May 25 1953
9. AGE (In years) (Months) (Days) (Hours) (Min.) - - - - 41		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) Hallway Polk Co Mo		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Carl Hinkle	13b. MOTHER'S MAIDEN NAME Corra Buehars	14. NAME OF HUSBAND OR WIFE None	
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 Mr. Carl Hinkle	
		ADDRESS Hallway Mo	

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Miscarriage DUE TO (c) Early rupture of Amnion		
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 7615	20. AUTOPSY? YES <input 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? Infant lived 4 hrs 8 mins.
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22. I hereby certify that I attended the deceased from **5-25 1953**, to **5-25 1953**, that I last saw the deceased alive on **5-25 1953**, and that death occurred at **4:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE M. J. Dumbrow	(Degree or title)	23b. ADDRESS 2 Bolivar Mo	23c. DATE SIGNED 5-26-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 26/53	24c. NAME OF CEMETERY OR CREMATORY Keed Cemetery	24d. LOCATION (City, town, or county) (State) Near Hallway Mo
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DATE REC'D BY LOCAL REG. May 29, 1953	REGISTRAR'S SIGNATURE Ralph Gordon	25. FUNERAL DIRECTOR'S SIGNATURE Corrus & Blue	ADDRESS Bolivar Mo
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(Licensed by State Board of Health on Reverse Side)

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

840
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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.

Student
Student Embalmer

Signed *Chas. J. Foster* _____

Licensed Embalmer No. *4154* _____

P. O. Address *Bolivar, 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.