

FILED NOV 8 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34536

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 5038 Registrar's No. 457

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

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Brookfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brookfield</u> <u>2582</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Switzer Rest Home</u>		d. STREET ADDRESS (If rural, give location) <u>142 E. Robard</u>	

3. NAME OF DECEASED
a. (First) FRED C. b. (Middle) KINNEY c. (Last) _____
4. DATE OF DEATH (Month) (Day) (Year) Nov. 4, 1954

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH July 16, 1874 9. AGE (In years last birthday) 80 10. MONTHS 0 11. DAYS 0 12. HOURS 0 13. MIN. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teamster ret 10b. KIND OF BUSINESS OR INDUSTRY Delivery service 11. BIRTHPLACE (City and State or Foreign Country) Brookfield, Missouri 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Calvin Kinney 13b. MOTHER'S MAIDEN NAME Rebecca - 14. NAME OF HUSBAND OR WIFE Etta Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Harold B Wright, Brookfield, Mo. ADDRESS _____

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage - Hypertension
INTERVAL BETWEEN ONSET AND DEATH 5 days
ANTECEDENT CAUSES Cerebral Arteriosclerosis, Arteriosclerosis
Morbidity 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.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO 331X

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Aug 20 1954 to Nov. 2, 1954, that I last saw the deceased alive on Nov. 2, 1954 and that death occurred at 8:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE Ray B. Haley, M.D. (Degree or title) 23b. ADDRESS Brookfield, Mo. 23c. DATE SIGNED 11-5-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Nov. 7, 1954 24c. NAME OF CEMETERY OR CREMATORY Rose Hill 24d. LOCATION (City, town, or county) (State) Brookfield, Mo.

DATE REC'D BY LOCAL REG. 11-5-54 REGISTRAR'S SIGNATURE Madeline Starnack 167 Rep. 25. FUNERAL DIRECTOR'S SIGNATURE Wright Funeral Home, Brookfield, Mo. ADDRESS _____

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 _____

Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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.