

FILED APR 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13450**
Registrar's No. **3093**

318 PRIMARY REG. DIST. NO. **1003**

No. 300
10-48

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Williamson			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo.)		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Marion		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) Rt. # 1			
3. NAME OF DECEASED (Type or Print) a. (First) Stanley b. (Middle) N. c. (Last) Hinckle			4. DATE OF DEATH (Month) (Day) (Year) April 5, 1955				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 12 1892		9. AGE (In years last birthday) 62 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (City and State or Foreign Country) Thompsonville Ill.		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Henry Hinckle		13b. MOTHER'S MAIDEN NAME Susan Wahl		14. NAME OF HUSBAND OR WIFE Ora Hinckle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. I		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ora Hinckle Marion Ill.			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of lung (primary site) (rt.) 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.					INTERVAL BETWEEN ONSET AND DEATH 6 mos.
19a. DATE OF OPERATION 4/1/55		19b. MAJOR FINDINGS OF OPERATION As above				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 16 2X			
22. I hereby certify that I attended the deceased from March 29, 1955 , to April 5, 1955 , that I last saw the deceased alive on April 5, 1955 , and that death occurred at 10: am. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) C. J. Pennington, M.D.				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 4/5/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-5-55		24c. NAME OF CEMETERY OR CREMATORY Local		24d. LOCATION (City, town, or county) (State) Marion Ill.	
DATE REC'D BY LOCAL REG. APR 6 1955		REGISTRAR'S SIGNATURE C. J. Pennington, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. H. Hoppe 4704 Washington Ave.			

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *Robert M. Murray*
.....

Licensed Embalmer No. *3749*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.