

Health,  
Welfare  
Public  
Service

300  
-56

Director, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-004819  
STATE FILE NUMBER

FILED MAR 11 1958

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 18

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>CLAY</u>	a. STATE <u>MISSOURI</u>	b. COUNTY <u>CLINTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EXCELSIOR SPRINGS</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>RURAL LAZROP 020</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>EXCELSIOR HOSPITAL</u>	Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>6 mi N.E. LAZROP</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <u>JAMES</u>	Middle <u>DENNIS</u>	Last <u>HINCHEY</u>	Month <u>FEB</u>	Day <u>28</u>	Year <u>1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1871</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>TURNERY, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PATRICK HINCHEY</u>			14. MOTHER'S MAIDEN NAME <u>SUSAN DEVER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT <u>JAMES HINCHEY, TURNERY MO.</u> Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u>		<u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral arterio sclerosis</u>	
	DUE TO (c) <u>Arterio sclerosis, generalized</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	<u>334X</u>
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from Mar 1952 to Feb 28, 58 and last saw him alive on Feb 28, 58  
Death occurred at 7:30 pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>George E. Anderson M.D.</u>	22b. ADDRESS <u>Excelsior Springs, Mo</u>	22c. DATE SIGNED <u>3-3-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-3-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CATHOLIC</u>
23d. LOCATION (City, town, or county) <u>CAMERON, MO</u>	(State)	

24. FUNERAL DIRECTOR <u>DE MOSS CRUNK</u> ADDRESS <u>CAMERON, MO</u>	25. DATE RECD. BY LOCAL REG. <u>3/3/58</u>	26. REGISTRAR'S SIGNATURE <u>Caroleen Hutchings</u>
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(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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *W. J. [Signature]*.....

Licensed Embalmer No. *25*  
P. O. Address *Comed*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.