

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010620

STATE FILE NUMBER

FILED APR 4 1958

Registration District No. 385 Primary Registration District No. 3039 Registrar's No.

0581  
300  
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

1. PLACE OF DEATH a. COUNTY <u>LINN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>LINN</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>MARCELINE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MARCELINE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>723 N. KANSAS</u>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>723 N. KANSAS</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>EVERETT</u> Last <u>KINNEAR</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>6</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>6-16-1892</u>		9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR AT&amp;SF Rwy.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>LINNEUS MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JOHN L. KINNEAR</u>				14. MOTHER'S MAIDEN NAME <u>IDA HOSFORD</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W W I</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>DALE BOACH MARCELINE</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma left kidney</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>180X</u>								INTERVAL BETWEEN ONSET AND DEATH	
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.) <u>0</u>						
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____									
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 <u>1950</u> to <u>3-1-58</u> and last saw her alive on <u>3-5-58</u> Death occurred at <u>1:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>John W. [Signature]</u> (Degree or title)				22b. ADDRESS <u>Marceline, Mo</u>				22c. DATE SIGNED <u>3-7-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
<u>BURIAL</u>		<u>3-8-58</u>		<u>MT. OLIVET</u>		<u>MARCELINE</u>		<u>Mo</u>	
24. FUNERAL DIRECTOR <u>MILLER-TILLOTSON</u>				ADDRESS <u>MARCELINE</u>		25. DATE RECD. BY LOCAL REG. <u>3-7-1958</u>		26. REGISTRAR'S SIGNATURE <u>Brookie Owens</u>	

APR 7 1958

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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 em  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Silburn K. Fella*

Licensed Embalmer No. *45*

P. O. Address *Marce*

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.