

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014858

STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 176 Primary Registration District No. 5-6-23 Registrar's No. 40

Health, Welfare Public Service

300  
1-56

0550  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Miller Greene</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Miller</u> 0550		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>Residence</u>		Length of stay in lb <u>Native</u>		d. STREET ADDRESS (If outside, give location) <u>Rt. 2, D.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>Orvel</u> Last <u>Hinshaw</u>				4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-1892</u>	9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lawrence Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hinshaw</u>				14. MOTHER'S MAIDEN NAME <u>Rennie Burkes</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>497-38-1056</u>		17. INFORMANT <u>Dixie Sexton Miller Mo.</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>unknown</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>perfectly normal heart conditions</u> DUE TO (c) <u>had suddenly, no one saw him</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>4344</u>				
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
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>5 Feb 58</u> and last saw her/him alive on <u>3-16-58</u> . Death occurred at <u>5 P. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W. S. Burkey M.D.</u>				22b. ADDRESS <u>Miller Mo.</u>		22c. DATE SIGNED <u>4-17-58</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-17-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Webb</u>		23d. LOCATION (City, town, or county) (State) <u>S.W. of Miller Mo.</u>		
24. FUNERAL DIRECTOR <u>Monnie Seiman Miller Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>4-14-58</u>		26. REGISTRAR'S SIGNATURE <u>W. S. Burkey</u>	

(Licensed Embalmer's Statement on Reverse Side)

MAR 27 1959

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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.....  
Signature of Student Embalmer

Signed.....  
*E. P. Lemire*

Licensed Embalmer No. *329*

P. O. Address *Miller*

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.