

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028009

STATE FILE NUMBER

FILED JUL 17 1958

Registration District No. 362

Primary Registration District No. 4531

Registrar's No. 29

5. 300

1-57

1. PLACE OF DEATH a. COUNTY Warren		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Warrenton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis 2179 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Katie Jane Home		Length of stay in lb 10 mos.	d. STREET ADDRESS (If outside, give location) 2328 Arkansas
3. NAME OF DECEASED (Type or print) First Cora Middle E. Last Hinchey			4. DATE OF DEATH Month July Day 14 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Sikeston, Mo.
13a. FATHER'S NAME David P. Powers		13b. MOTHER'S MAIDEN NAME Sarah Frances Rae	14. NAME OF HUSBAND OR WIFE John F. Hinchey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 497-09-4852-B	17. INFORMANT Mr. Lon Hinchey Address 3635 Gasconade St. Louis, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident recurrent			INTERVAL BETWEEN ONSET AND DEATH 2 ho
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis -			no
DUE TO (c) Senile Dementia			no
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"/> 2
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 o.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 5-29-57 to 7-14-58 and last saw her alive on 7-11-58 Death occurred at 5:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Donald D. Schloche M.D.		22b. ADDRESS Sikeston Mo	22c. DATE SIGNED 7-14-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-15-58	23c. NAME OF CEMETERY Sikeston	23d. LOCATION (City, town, or county) (State) Sikeston, Mo.
24. FUNERAL DIRECTOR ADDRESS F.W. Nieburg & Co., Warrenton, Mo.		25. DATE RECD. BY LOCAL REG. July 15, 1958	26. REGISTRAR'S SIGNATURE Lloyd Logan

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

