

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008858

FILED APR 6 1959 Registration District No. 82 Primary Registration District No. 5311 STATE FILE NUMBER Registrar's No. 45

1. PLACE OF DEATH a. COUNTY <i>Cooper</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY <i>Cooper</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Pilot Grove - Insp.</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>4 mi. North Grove</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4 mi. North Grove Pilot Grove</i> Length of stay in 1b <i>16 yrs</i>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <i>HORTENSE - - - - - KINNEY -</i>			4. DATE OF DEATH Month Day Year <i>March 27-1959</i>		
--	--	--	--	--	--

5. SEX <i>3</i> <i>Female</i>	6. COLOR OR RACE <i>3</i> <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 25-1883</i>	9. AGE (In years last birthday) <i>76</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
-------------------------------	--	--	--	---	---	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>	11. BIRTHPLACE (City and state or country) <i>Cooper County MO</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
---	--	---	--

13a. FATHER'S NAME <i>Unknown</i>	13b. MOTHER'S MAIDEN NAME <i>Unknown</i>	14. NAME OF HUSBAND OR WIFE <i>Porter Kinney</i>
--------------------------------------	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Porter Kinney - Pilot Grove MO</i>	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) <i>Metastatic carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Primary probably gall bladder</i>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Bursitis Feb 27, 1959</i>		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 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 <i>2-18-59</i> to <i>3-27-59</i> and last saw her alive on <i>3-16-59</i> Death occurred at <i>2:20</i> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>T.C. Beckett MD</i> (Degree or title)	22b. ADDRESS <i>Bonnville MO</i>	22c. DATE SIGNED <i>3-28-59</i>
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>March 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bunceton Cal. Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Bunceton MO</i>
--	--------------------------------	---	---

24. FUNERAL DIRECTOR <i>Nays & Painter</i>	25. DATE RECD. BY LOCAL REG. <i>3/30/59</i>	26. REGISTRAR'S SIGNATURE <i>D. Cooper</i>
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 L. Painter*

Licensed Embalmer No. *4069*
P. O. Address *Pilot Grove*

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.