

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 6 1959

354

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59-034945

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

MEMORANDUM

1. PLACE OF DEATH a. COUNTY <b>Texas</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Texas</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cass twp.</b>		Length of stay in 1b <b>3 hrs.</b>		c. CITY OR TOWN <b>Clara, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1 mi. No. Simmons</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Piney twp.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>ELWARD</b> Last <b>KINNEY, SR.</b>				4. DATE OF DEATH Month <b>9-</b> Day <b>27-</b> Year <b>1959</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6-9-1891</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>		11. BIRTHPLACE (City and state or country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Kinney</b>			13b. MOTHER'S MAIDEN NAME <b>Mollie Kinney</b>			14. NAME OF HUSBAND OR WIFE <b>Bob Kinney, Des Moines, Iowa</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>478-20-8134</b>		17. INFORMANT <b>Bob Kinney, Des Moines, Iowa</b>				
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>probable cerebral thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>		
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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.		Month, Day, Year _____							
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 <b>VIEWED</b> the deceased <b>ON</b> <b>9-26-59</b> to _____ and last saw her <b>ON</b> _____ to _____ Death occurred at <b>approx. 2:30</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>James L. Tenby (Coroner)</b>				22b. ADDRESS <b>Cabool, Mo.</b>				22c. DATE SIGNED <b>9-27-59</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>burial</b>		23b. DATE <b>19-1-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cabool Cemetery</b>			23d. LOCATION (City, town, or county) <b>Cabool, Mo.</b>			(State)
24. FUNERAL DIRECTOR <b>Elliott Gentry, Cabool, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>9-28-59</b>		26. REGISTRAR'S SIGNATURE <b>Raynell Kingman</b>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 22 1959

OCT 1 1959

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 James S. Kenton

Licensed Embalmer No. 4778

P. O. Address Calrod, M

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.