JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1 1960

60-038041
STATE FILE NUMBER

NDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1083

1. PLACE OF DEATH
a. COUNTY: GREENE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: SPRINGFIELD — Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: City Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY: GREENE
c. CITY OR TOWN: SPRINGFIELD — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2019 N. Prospect — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Eldridge — Last: Kynion

4. DATE OF DEATH: Month: October — Day: 26, — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 12 Jan. 1893

9. AGE (last birthday): 67 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus Driver

10b. KIND OF BUSINESS OR INDUSTRY: Municipality

11. BIRTHPLACE (City and state or country): Missouri, Springfield

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Frank Kynion

13b. MOTHER'S MAIDEN NAME: (Unknown) Vaughn

14. NAME OF HUSBAND OR WIFE: Janie Kynion

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 491-03-3224

17. INFORMANT: Janie Kynion(Wife) Address: Springfield, 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): Cardio-Pulmonary Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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 ☐ NOT WHILE AT WORK ☐

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 9/29/60, to 10/26/60 and last saw her/him alive on 10/4/60
Death occurred at 7:15 AM P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Lyman W. Brown M.D.

22b. ADDRESS: 311½ College Springfield, Missouri

22c. DATE SIGNED: 10/28/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10/28/60

23c. NAME OF CEMETERY OR CREMATORY: National Cemetery

23d. LOCATION (City, town, or county) (State): Springfield, Missouri

24. FUNERAL DIRECTOR ADDRESS: KLINGNER MORTUARY, INC. SPRINGFIELD MO.

25. DATE RECD. BY LOCAL REG.: Effie G. Melton 10-28-1960

26. REGISTRAR'S SIGNATURE

jhc

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

NOV 1 0 1960

NOV 1 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Ogle Stone

Signature of Student Embalmer

Licensed Embalmer No. 41

P. O. Address SPRINGFIELD

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.