

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045489

FILED VS. DEC 21 1960

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 129

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Clinton</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>		Length of stay in 1b <b>DOA</b>		c. CITY OR TOWN <b>Turney</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>Cameron Comm. Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3mi. E 1mi of Turney</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES MICHAEL HINCHEY</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>5</b> Year <b>1960</b>						
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>7-3-1878</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Clinton Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Patrick Hinchey</b>			13b. MOTHER'S MAIDEN NAME <b>Sue Never</b>			14. NAME OF HUSBAND OR WIFE <b>Josephine Hinchey</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>Yes</b>		17. INFORMANT <b>Charles Hinchey Turney Mo</b>				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) <b>Valvular heart disease - decompensation</b>								INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Arteriosclerosis -</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) <b>Pulmonary emphysema</b>						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 attended the deceased from <b>Aug. '58</b> to <b>5 Dec '60</b> and last saw him alive on <b>11-25-60</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <b>George C. Anderson M.D.</b>				(Degree or title)		22b. ADDRESS <b>Excelsior Springs, Mo.</b>		22c. DATE SIGNED <b>12-8-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 7 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery</b>		23d. LOCATION (City, town, or county) <b>Cameron Mo.</b>			(State)		
24. FUNERAL DIRECTOR <b>Poland Funeral Home Cameron Mo.</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>12-12-60</b>		26. REGISTRAR'S SIGNATURE <b>Francis Crawford</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Laurence J. Thompson

Licensed Embalmer No. 4735

P. O. Address Camden,

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.