

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035568

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 189

STATE FILE NUMBER

AMENDED

FILED SEP 25 1961

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Scott</u>		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>	Length of stay in lb <u>17 Yrs.</u>	c. CITY OR TOWN <u>Sikeston</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>611 Greer St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>611 Greer St.</u>	
				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Logan</u> Last <u>Kinsey</u>			4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>61</u>		
---	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-1888</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
--------------------	-------------------------------	---	--	-----------------------------------	----------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Bloggett, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
--	--	---	--	--	--	---	--

13a. FATHER'S NAME <u>David Kinsey</u>		13b. MOTHER'S MAIDEN NAME <u>Marinda Kemp</u>		14. NAME OF HUSBAND OR WIFE <u>Elvira Kinsey</u>	
---	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Larry Kinsey</u> Address <u>Sikeston, Mo.</u>	
---	--	---------------------------------------	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Cor Pulmonale</u>		<u>2 yrs</u>
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1. Possible Carcinoma Lung.</u>		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 <u>10-9-59</u> to <u>9-23-61</u> and last saw her/him alive on <u>9-19-61</u> Death occurred at <u>5:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.				
---	--	--	--	--

22a. SIGNATURE (Degree or title) <u>Andy B. Smith MD</u>		22b. ADDRESS <u>Sikeston Mo</u>		22c. DATE SIGNED <u>9-23-61</u>
---	--	------------------------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-25-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Gideon Cem.</u>	23d. LOCATION (City, town, or county) <u>Clarkton, Mo.</u>	
--	-------------------------------	--	---	--

24. FUNERAL DIRECTOR ADDRESS <u>Albritton Funeral Home, Sikeston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-23-61</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Ora Du Vall Reg.</u>	
--	--	--	---	--

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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 by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Raymond L. Ruffin

Licensed Embalmer No. 4798

P. O. Address Beattie, Mo

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.