

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-036182

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 55 Primary Registration District No. 4082 Registrar's No. 96

FILED OCT 30 1961

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Carroll</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bogard</u>		Length of stay in lb <u>32 yrs</u>		c. CITY OR TOWN <u>Bogard</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>None</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Sherman</u> Last <u>Pinkerton</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-30-1867</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</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>Retired Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Livingston County</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William B. Pinkerton</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah A. Cooch</u>		14. NAME OF HUSBAND OR WIFE <u>Emily Rollen</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Gene Eichenhour, Bogard, 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>Infirmities of old age.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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. <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>Oct. 19 / 61</u> to <u>Oct. 21, 1961</u> and last saw him alive on <u>Oct. 19/61</u> Death occurred at <u>5:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <u>Dr. Arthur B. Stetson M.D.</u>			22b. ADDRESS <u>Carrollton, Missouri</u>		22c. DATE SIGNED <u>Oct. 22/61</u>		
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 23, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cloma Cemetery</u>		23d. LOCATION (City, town, or County) <u>Bogard Mo</u>		(State)
24. FUNERAL DIRECTOR <u>Dicheneyson-Rice-Bogard, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>10-23-61</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Herbert Coates</u>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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 Samuel M. Rice

Licensed Embalmer No. 5087

P. O. Address Bogard, 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.