

REG. 16 16 1941
Regis. District No. 247

Primary Registration District No. 3018

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County HENRY
(b) City or town LADUE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
COMMUNITY CLINIC
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 hrs.
In this community Life! (Specify whether years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Henry
(c) City or town Ladue, Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Near Ladue, Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

8. (a) PRINT FULL NAME JOSEPH NORMAN HINDES

8. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced CHILD

6. (b) Name of husband or wife CHILD 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased SEPT. 22 1939
(Month) (Day) (Year)

8. AGE: Years 1 Months 10 Days 7 If less than one day ✓ br. min.

9. Birthplace LADUE MO.
(City, town, or county) (State or foreign country)

10. Usual occupation CHILD

11. Industry or business ✓

MOTHER FATHER { 12. Name JOSEPH V. HINDES

13. Birthplace CAMPEN Co. MO.
(City, town, or county) (State or foreign country)

14. Maiden name DOROTHY MAE YEAL

15. Birthplace DEEPWATER MO.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph V. Hinder

(b) Address Ladue Mo.

17. (a) BURIAL (b) Date thereof 7/30/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LADUE MO.

18. (a) Signature of funeral director Charles W. Bourant

(b) Address Clinton Mo.

19. (a) 7-6-41 (b) Dr. R. Hampton
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month 7 day 29
year 1941 hour 2 minute 45 AM.

21. I hereby certify that I attended the deceased from 7-28-41
that I last saw him alive on 7-29
and that death occurred on the date and hour stated above.

Immediate cause of death Skull fracture and shock Duration 5 hrs

Due to 186

Due to 186

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 7-28-41

(c) Where did injury occur? Ladue, Henry Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on farm

While at work? Play (Specify type of place) (e) Means of injury Kicked by mule

23. Signature Eugene J. Hinder (M. D. or other) MD.

Address Clinton Mo. Date signed 7-29-41

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 7,

District File Number 8-41-1333.

Date Filed 8-14-41

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3779

P. O. Address Clinton 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25205

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hrs
(Specify whether years, months or days)
In this community life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry
(c) City or town La Due Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Near La Due
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Joseph N. Kindels

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex.....

5. Color or race.....

6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a).....

(b) Date thereof.....

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a).....

(Date received local registrar)

(b) W. J. Rehnolter

(Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 29
year 1941 hour 10 minute M.

21. I hereby certify that I attended the deceased from 19 ;
that I last saw him alive on 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death..... Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

S-25205