

REC'D MAY 17 1938

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

14077

Do not use this space.

1. PLACE OF DEATH

 (a) County Buchanan
 (b) Township
 (c) City St. Joseph
 (e) Length of residence in city or town where death occurred yrs. mos. 5 hours
Registration District No. 85Primary Registration District No. 1001Registered No. 438
 (d) Street No. Massouri Methodist Hospital
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME EARL DOUGLAS STINNETT(a) Residence, No. FARM NEAR FILLMORE St.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MALE

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

MRS. OPAL STINNETT6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MARCH-29-1916

7. AGE

YEARS 22MONTHS 0DAYS 18

If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. FARMER

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN), FILLMORE (STATE OR COUNTRY) MO13. NAME WINEFIELD STINNETT14. BIRTHPLACE (CITY OR TOWN), FORDLAND (STATE OR COUNTRY) MO15. MAIDEN NAME MARY JANE POE16. BIRTHPLACE (CITY OR TOWN), WOODBINE (STATE OR COUNTRY) IOWA17. INFORMANT (ADDRESS) J. J. Stinnett
Fillmore Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE FILLMORE MO DATE 4-19- 193819. FUNERAL DIRECTOR J. FRED TERHUNE (ADDRESS) SAVANNAH MO20. FILED 4-18 1938 J. J. Methodist Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 17 193822. I HEREBY CERTIFY, That I attended deceased from April 16 1938 to April 17 1938I last saw him alive on April 17 1938 Death is said to have occurred on the date stated above, at 7:30 A.M.

The principal cause of death and related causes of importance were as follows:

Acute brain injuryFracture of skull?Intracranial hemorrhage

Other contributory causes of importance:

Medullary edemaName of operation none Date ofWhat test confirmed diagnosis? Cerebral Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide Accident Date of injury 4-16-38Where did injury occur? Holt County, Missouri (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place. Public highwayManner of injury auto wreck accidentNature of injury Intracranial hemorrhage24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. B. Larson M. D.(Address) St. Joseph, Mo85

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

210 m
95-

STATEMENT BY LICENSED EMBALMER

I, J. Fred Turkum, Licensed Embalmer No. 1279

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed J. Fred Turkum

Licensed Embalmer No. 1279

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.)

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
MEMPHIS, TENNESSEE

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

14077
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 80
 (b) Township _____ Primary Registration District No. 1001 Registered No. 438
 (c) City St. Joseph (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Carl Douglas Stinnett

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
22 0 18

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 17, 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

acute brain injury fracture of skull
with cerebral hemorrhage
medullary edema
 Other contributory causes of importance:
Non collision accident car turned over in ditch

Date of onset

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury automobile accident
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) E. J. Jensen, M. D.

(Address) St. Joseph Mo.

SUPPLEMENT

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 ST. JOSEPH, MISSOURI
 DEPARTMENT OF HEALTH
 HALL NO. 100 (N.W.) A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY THE BOARD OF HEALTH
 IF PROPERTY CLASSIFIED, CLASSIFICATION TO BE MADE BY THE BOARD OF HEALTH

