

FILED JUN 14 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

19763

State File No.

Registration District No. 852

Primary Registration District No. 6120

Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Pollock Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 62 years (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME ORY ARENA SINCLAIR

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 9 1878  
(Month) (Day) (Year)

8. AGE: Year 61 62 Months 11 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Pollock, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation at home on farm

11. Industry or business \_\_\_\_\_

12. Name William Sinclair

13. Birthplace Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Emeline Pluses

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

16. (a) Informant Thos W Sinclair

(b) Address Pollock, Missouri

17. (a) burial (b) Date thereof May 23/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Campbell's Pollock

18. (a) Signature of funeral director C. H. Schwan

(b) Address W. Va

19. (a) June 6 1940 (b) C. H. Hagans  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan  
(c) City or town Pollock, Mo. Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route # 2  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21  
year 1940 hour 5 minute 00 P. M.

21. I hereby certify that I attended the deceased from May 19, 1940, to May 21, 1940  
that I last saw her alive on May 20, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Carcinoma

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Refused; Drs. Siffert & Boninville, Centerville  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
(d) 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 J. C. Roberts (M. D. or other) \_\_\_\_\_  
Address Pollock, Mo. Date signed 5/22/40

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

RECEIVED

District Health Officer No. 10

District-File Number 6-40-1198

Date Filed JUN 11 1940

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.....

Frank D. Schoene

Registered Apprentice No. ....

working under my personal supervision.

Signed

Frank D. Schoene

Licensed Embalmer No. 2016

P. O. Address Milan, 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. **19763**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **832**

Primary Registration District No. **6120**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Sullivan**  
(b) City or town **Paris**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME

**Ory Arena Sinclair**

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **7**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **8**

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased

**June 9 1878**  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

**61 11 12**

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) **July 11 1940** (b) **Oleo Hagan**  
(Deceased's signature) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **21**  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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)

(d) 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 **J. C. Roberts** (M. D. or other) \_\_\_\_\_

Address **Pallock** \_\_\_\_\_ signed

SUPPLEMENTARY

