

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32106

Registration District No. 3280CT 22 1944 Primary Registration District No. 3017 Registrar's No.

1. PLACE OF DEATH:

- (a) County Greene
 (b) City or town Trenton
 (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 3
 (Specify whether

In this community
years, months or days)3. (a) PRINT FULL NAME John Sinclair

8. (b) If veteran, name war _____ 8. (c) Social Security No. None

4. Sex male 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 Dec 31 1875
 (Month) (Day) (Year)

8. AGE: Years 64 Months 9 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Kingston mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Tom Sinclair

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

14. Maiden name Mary Coy

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

16. (a) Informant's own signature Don Miller

- (b) Address 105 W 2nd

17. (a) burial (b) Date thereof 10-9-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Maple Grove Cem

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

- (b) Address 1016 ...

19. (a) Oct 9-40 (b) Gene D. ...
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Greene

- (c) City or town Trenton
 (If outside city or town limits, write "RURAL")

- (d) Street No. 105 W 2nd
 (If rural, give location)

- (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7
 year 1940 hour 10 minute am

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 Heart Failure Duration _____

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations noneOf autopsy none

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 Oct 7-1940

- (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? 300 Public place

- While at work? yes (Specify type of place) _____
 (e) Means of injury _____

23. Signature Gene D. ... Acting Coroner (M. D. or other) _____

Address Trenton mo Date signed 10/8/40

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 importa

2002

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.....

Charles D. Simpson

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Charles D. Simpson

Licensed Embalmer No.....

3109

P. O. Address.....

Frenton 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. **32106**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **328**

Primary Registration District No. **3017**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Greene**

(b) City or town **Trenton**
(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 years, months or days)

In this community.....

3. (a) PRINT FULL NAME **John Sinclair**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widwed, married, divorced

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years **64** Months **9** Days **8** If less than one day min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) (Date received local registrar) (b) (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 **Oct** day **7** year **1940** hour..... minute..... M.

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

Immediate cause of death **Heart Failure**

Organic Heart Disease

Due to **Coronary Thrombosis**

Due to.....

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

Sept 1940

Major findings: Of operations..... **4519**

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 **Oct-7-1940**

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

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

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

23. Signature **G. H. Henderson** (M. D. or other)

Address **Trenton** signed

SUPPLEMENTARY

