

S. No. 2  
11-10-39  
5-7-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22714

Registration District No. 5274

Primary Registration District No. 6-273-4547 Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Worth

(b) City or town Grant City Mo.  
(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 50 yrs.  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Worth 113

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

(d) Street No. Grant city, Hetchell, Miss.  
(If used, give location)

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

8. (a) PRINT FULL NAME Samuel O. Rinehart

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 widowed

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

7. Birth date of deceased December 24 1859  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>4</u>	<u>24</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business farming

**MOTHER FATHER**

12. Name Fred Rinehart

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

14. Maiden name Elizabeth Good

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

16. (a) Informant Earl Rinehart

(b) Address Grant City, Mo.

17. (c) burial (b) Date thereof May 22 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Honey Grove Cemetery

18. (a) Signature of funeral director Arch C. Duffer

(b) Address Grant City, Mo.

19. (a) May 27 - 1943 (b) Adelbert Scadden  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 19  
year 1943 hour 112 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 10, 1943, to May 19, 1943; that I last saw him alive on May 19, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death myocardial degeneration of heart

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

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

Other conditions 928  
(Include pregnancy within 3 months of death)

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

Of autopsy no

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 W. H. D.

Address Grant City, Mo. Date signed 5-20-43

Duration 54 yrs

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

13  
1  
0

1104

(Licensed Embalmer's Statement on Reverse Side)

**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 Arch C. Sample  
Licensed Embalmer No. 3252  
P. O. Address Grant City, Md

**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.**