

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

29060
Do not use this space.

FILED AUG 16 1943

1. PLACE OF DEATH
(a) County Pike Registration District No. 277
(b) Township _____ Primary Registration District No. 4408-4411 Registered No. 35-8
(c) City Bowling Green (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 Charles Enich McPinnis
(a) Residence, No. Pike 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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lillian McPinnis
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 21st 1866
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 76 11 1
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) (STATE OR COUNTRY) Montgomery Co. MO
13. NAME John McPinnis
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO
15. MAIDEN NAME Mary McPinnis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO
17. INFORMANT (NAME) (ADDRESS) Mrs Lillian McPinnis
Jack Smith, Ill
18. BURIAL, CREMATION, OR REMOVAL PLACE Parson DATE 7 29 1943
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Grace Banford
Bowling Green, MO
20. FILED July 30, 1943 Mrs Frank Gads
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-21 1943
22. I HEREBY CERTIFY, That I attended deceased from 7-15 1943 to 7-21 1943
I last saw him alive on 7-21 1943. Death is said to have occurred on the date stated above, at 11:50 p.m.
The principal cause of death and related causes of importance were as follows:
Myocardial Failure Date of onset 7-21-43
Other contributory causes of importance: hypostatic pneumonia 7-18-43
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 _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify _____
(Signed) GILMAN R. JONES M. D.
(Address) Bowling Green, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

11422

RECEIVED

District Health Officer No: 10

Case File Number 8-43-1415

Date Filed AUG 13 1943

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

Ernest A. Ruff

Licensed Embalmer No. 3944

P. O. Address Bowling Green

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Pike
 (b) City or town Bowling Green
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Charles E. McGinnis
 3. (b) If veteran, _____ name war _____
 3. (c) Social Security No. _____

4. Sex m 5. Color or race B
 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 21 1898
(Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days _____
Unless 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) _____ (b) _____
(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 21
 year 1943 hour _____ 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 _____

Due to myocardial failure 7-21-43
 Due to Bronchial pneumonia
 Other conditions Hepatic pneumonia
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____ 107
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?

(Specify type of place)
 While at work? _____ (c) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

29060