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5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 13 1945

State File No. 20234

Registration District No. 99 Primary Registration District No. 5380 Registrar's No. 42

1. PLACE OF DEATH:
(a) County Dekalb
(b) City or town Stewartsville 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 63 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County DeKalb
(c) City or town Stewartsville Rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mose H. Hinderks
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mayme
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased August (Month) 7 (Day) 1881 (Year)

8. AGE: Years 63 Months 9 Days 24 If less than one day hr. min.

9. Birthplace Stewartsville (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farming
11. Industry or business

FATHER
12. Name Casper Hinderks
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Dora Tietge
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mrs LeRoy Brown
(b) Address Stewartsville
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Maple Grove
18. (a) Signature of funeral director F. J. Ryan
(b) Address Stewartsville Mo
19. (a) June - 2-1945 (Date received local registrar) (b) John Clarke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
year 1945 hour 7:00 minute P. M.

21. I hereby certify that I attended the deceased from
May 31, 1945 to , 19
that I last saw h/im alive on May 31, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardial Anoxia	
Due to Coronary Occlusion	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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
(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? Means of injury

23. Signature Dr. A. Van De Linden (M. D. or other) DO
Address Stewartsville Mo Date signed 6-2-45

1378 (Licensed Embalmer's Statement on Reverse Side)

MAR 27 1959

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.

RECEIVED
District Health Officer No. 11,
District File Number.....
Date Filed.....

Signed J. G. Lyon

Licensed Embalmer No. 952

P. O. Address Stevensville Mont

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, fact should be so stated above.

. No. 2B
5M—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 99 Primary Registration District No. 5380 Registrar's No. X 25

1. **PLACE OF DEATH:**
(a) County DeKalb
(b) City or town Rural 15 Township
(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

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

3. (a) PRINT FULL NAME Mose A Hinderbaa

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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 (Month) 7 (Day) 58 (Year)

8. **AGE:** Years 63 Months 9 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) John Cooper (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug Day 7 year 1945 hour 5 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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
(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? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-20234