

FILED OCT 3 1946 STANDARD CERTIFICATE OF DEATH

30085  
State File No.

Registration District No. 137

Primary Registration District No. 3023

Registrar's No. 173

1. PLACE OF DEATH:

(a) County Henry  
(b) ~~Clinton~~ Bethlehem Twp  
(c) Name of hospital or institution: Clinton General Hospital  
(d) Length of stay: In hospital or institution 7 days  
In this community 16 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry  
(c) City or town Rural  
(d) Street No. Bethlehem Twp  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Timothy B. Bernhorst

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced divorced  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 23 years  
7. Birth date of deceased 1-23-1868

8. AGE: Years 78 Months 7 Days 14 If less than one day hr. min.

9. Birthplace Indiana

10. Usual occupation Farmer

11. Industry or business None

12. Name UNKNOWN  
13. Birthplace UNKNOWN  
14. Maiden name UNKNOWN  
15. Birthplace UNKNOWN

16. (a) Informant Edward Bernhorst

(b) Address Clinton Mo

17. (a) Burial (b) Date thereof 9 11 46

(c) Place: burial or cremation Bethlehem cem

18. (a) Signature of funeral director Fred Wilkinson  
(b) Address Clinton Mo  
19. (a) 9-10-46 (b) R R Kenney

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7 year 1946 hour 6 minute 15 P.M.  
21. I hereby certify that I attended the deceased from Aug 21 1946 to Sept 7 1946  
(that I last saw him alive on Sept 7 1946 and that death occurred on the date and hour stated above)

Immediate cause of death Hypertensive pneumonia Duration 24 hours

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Chronic Nephritis  
(Include pregnancy within 3 months of death)

Major findings: 131B  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signatures: Dr. R. P. Hallinger M.D. or other \_\_\_\_\_  
Address Clinton Mo Date signed 9/10/46

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

20250

RECEIVED

Director Health Officer No. 7,

Division of Health 9-46-960

Date Filed 10-2-46

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 *Fred Wilkinson*

Licensed Embalmer No. *7478*

P. O. Address *Clifton*

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.