

FILED AUG 2 1945
Registration District No. **4023**

Primary Registration District No. **4023**

Registrar's No. **40**

1. PLACE OF DEATH:
 (a) County **Barry**
 (b) City or town **Exeter**
(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 **life**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Barry 5**
 (c) City or town **Exeter**
(If outside city or town limits, write "RURAL")
 (d) Street No. **0**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **John B. Pinkney**
 3. (b) If veteran, name war **--**
 3. (c) Social Security No. **--**

4. Sex **M 0** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **M /**
 6. (b) Name of husband or wife **Myrtle Pinkney**
 6. (c) Age of husband or wife if alive **87 1/2** years
 7. Birth date of deceased **March 5, 1876** **ARK.**
(Month) (Day) (Year)

8. AGE: Years **71** Months **2** Days **27**
 If less than one day **hr. min.**

9. Birthplace **do not know** **ARK. /**
(City, town, or county) (State or foreign country)
 10. Usual occupation **laborer**

11. Industry or business _____
 12. Name **Bud Pinkney**
 13. Birthplace **do not know** **ARK. /**
(City, town, or county) (State or foreign country)
 14. Maiden name **Do Not Know**
 15. Birthplace **do not know** **a**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Myrtle Pinkney**
 (b) Address **Exeter, Mo.**
 17. (a) **burial** (b) Date thereof **6/4/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place of burial or cremation **Exeter**

18. (a) Signature of funeral director **W.H. Moore**
 (b) Address **Cassville, Mo.**
 19. (a) **June 15-1945** (b) **Grace Williams**
(Date received local registers) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **2**
 year **1945** hour **8 pm.** minute _____ M.
 21. I hereby certify that I attended the deceased from **May 31**
 _____, 1945 to **June 2**, 1945;
 that I last saw him alive on **June 2**, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death **apoplexy - Brain - Acute**
 Duration _____

Due to **?**
 Due to _____
 Other conditions **1**
(Include pregnancy within 3 months of death)

Major findings: **(320)**
 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? **2**

While at work? _____
(Specify type of place) (e) Means of injury
 23. Signature **W.R.M. Clure** (M.D. or other) **20**
 Address **Cassville, Mo** Date signed **6-7-45**

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

5
10
0

RECEIVED

District Health Officer No. 6;

District File Number 745-841

Date Filed JUL 31 1945

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.....

Licensed Embalmer No. 3453

P.O. Address Cassville, 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, fact should be so stated above.