DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1940

Registration District No. 173

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33024

Primary Registration District No. 6018A

Registrar's No. 160

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

1. PLACE OF DEATH:
(a) County St Francois Co
(b) City or town Farmington Rt 2 St Francois Co
(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 2 (Specify whether years, months or days)
In this community Twenty Eight years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Francois
(c) City or town Farmington Mo R 2
(If outside city or town limits write "RURAL")
(d) Street No. 0 St Francois Twp
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Mr. John Wm Pinkerton
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Caroline J Woolridge
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Oct. 4 1858 (Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 7 If less than one day ____ hr. ____ min.

9. Birthplace Ste Genevieve Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
MOTHER FATHER
12. Name Wm H Pinkerton
13. Birthplace Dont know (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Bertrand
15. Birthplace Dont know (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Kenneth Yeager
(b) Address Scheller Ill
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Pilot Knob Memorial Park
18. (a) Signature of funeral director Farmington Mo
(b) Address Farmington Mo
19. (a) Sept 12-1940 (Date received local registrar) (b) B. L. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11
year 1940 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from July 4, 1940, to Sept 9, 1940
that I last saw him alive on Sept 9, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: General Paralysis	
Due to: Chronic Bronchitis	
Due to: Influenza	
Due to: Portal Pneumonia	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
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? (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 C Applebury (M. D. or other)
Address Farmington Mo Date signed Sept 12-40

(Licensed Embalmer's Statement on Reverse Side)

528

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

me, Registered Apprentice No.

working under my personal supervision.

Signed C Hugo Cozza

Licensed Embalmer No. 4084

P. O. Address Farmington Ohio

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.

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32024

Registration District No. 173 Primary Registration District No. 6018 A Registrar's No.

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Farmington St Fran Twp
(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)

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) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Wm Pemberton
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 W
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years.

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 7 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11
year 1940 hour 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: General Exhaustion	
Due to: Chronic bladder infection	
Due to: Partial Paralysis	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Cerebral Hemorrhage	
Of operations None	
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 9-29-40

SUPPLEMENTARY

Chronic bladder infection
Infected
Catheter