

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5895

5895

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 607L Registrar's No. 5895

1. PLACE OF DEATH a. COUNTY ST. FRANCIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY ST. GENEVIEVE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BONNE TERRE #1	c. LENGTH OF STAY (In this place) 1	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FARMINGTON R #4	d. STREET ADDRESS (If rural, give location) FARMINGTON, MO.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Marion Township			

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) PINKSTON c. (Last) PINKSTON		4. DATE OF DEATH (Month) (Day) (Year) FEB 13 1949	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEPT. 4 1875
9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 5 Days 9	IF UNDER 1 HRS. Hours Mins. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARE OF HOME		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois
		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13a. FATHER'S NAME Wm. McCLANAHAN	13b. MOTHER'S MAIDEN NAME JULIA GODAT	14. NAME OF HUSBAND OR WIFE William PINKSTON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Mrs. Jewel Pinkston R #1 ADDRESS Bonne Terre, Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia ANTECEDENT CAUSES DUE TO (b) Arterio sclerotic heart disease DUE TO (c) Arterio sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 3 days
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION H²	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 12, 1949**, to **Feb 12, 1949**, that I last saw the deceased alive on **Feb 12, 1949**, and that death occurred at **4:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. H. Appleberry M.D.	23b. ADDRESS Flat River MO	23c. DATE SIGNED 2-15-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 2-15-49	24c. NAME OF CEMETERY OR CREMATORY OSBURY CHAPEL	24d. LOCATION (City, town, or county) (State) FARMINGTON R. #4 MO.
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DATE REC'D BY LOCAL REG. Feb 15, 1949	REGISTRAR'S SIGNATURE Ether Rudloff	25. FUNERAL DIRECTOR'S SIGNATURE C. Z. Sauer & Son, Desloge ADDRESS Desloge, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

9400

RECEIVED

Health Officer No. 4
249-2
2-21-4

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 _____

_____ Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed C. J. Lopez
Licensed Embalmer No. 1671
P. O. Address Deesloze W

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.