Dr. Perrin

OHIO DEPARTMENT OF HEALTH

COLUMBUS

CERTIFICATE OF DEATH

Department of Commerce — Bureau of the Census

Reg. Dist. No. 1432 Primary Reg. Dist. No. 2430

State File No. 13012 Registrar's No. 21

MARGIN RESERVED FOR BINDING

THIS CERTIFICATE SHALL BE PRINTED LEGIBLY OR TYPEWRITTEN IN UNFADING INK.

V.S. 11

1. PLACE OF DEATH:

(a) County Ross

(b) Chillicothe (City, Village, Township)

(c) Name of hospital or institution: 449 North High Street (If not in hospital or institution, write street No. or location)

(d) Length of stay: In hospital or institution ____ (Days)

In this community ____ (Years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County Ross

(c) City or village Chillicothe (If outside city or village, write RURAL)

(d) Street No. 449 North High Street (If rural, give location)

MAR 1945

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

3. FULL NAME George Kinkliff

(a) If veteran, name war ____ (b) Social Security No. ____

4. Sex Male 5. Color or race White 6.(a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Minnie Krick 6.(c) Age of husband or wife if alive ____ years

7. Birth date of deceased December (Month) 13 (Day) 1854 (Year)

8. AGE: Years	Months	Days	If less than one day
90	1	22	hr. ____ min. ____

9. Birthplace Marion Co. (City, town, or county) New York (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business ____

Mother Father

12. Name Frederick Kinkliff

13. Birthplace ____ (City, town, or county) Germany (State or foreign country)

14. Maiden name Elizabeth Kirsch

15. Birthplace ____ (City, town, or county) Germany (State or foreign country)

16. (a) Informant's signature Miss Thea Kinkliff

(b) Address Chillicothe, Ohio

17. (a) Burial, ~~cremation, or other~~: (b) Date 2-7-1945 (Month) (Day) (Year)

(c) Place Grandview

(d) Jesse Jacobs (Name of Embalmer) 3277-F (Lic. No.)

18. (a) C. J. Ware (Signature of Funeral Director) 1821 (Lic. No.)

(b) Address Chillicothe, Ohio

19. (a) 2-7-45 (Date received local registrar) (b) E. R. Muller (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month February day 5

year 1945 hour 8 minute 10 A.M.

21. I hereby certify that I attended the deceased from Jan 29, 1945, to Feb. 5, 1945, that I last saw him alive on Feb. 4, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardio-renal insufficiency	
Due to ____	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) Senility	
Major findings of operation ____	
Major findings of autopsy ____	

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 Village) (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) How did injury occur? ____

23. Signature David A Perrin (Specify if Doctor of Medicine or Osteopathy)

Address Chillicothe O Date signed 2/7/45

Quellenangabe:
"Ohio, United States Aufzeichnungen," Aufnahmen, FamilySearch (https://www.familysearch.org/ark:/61903/3:1:S3HT-DRSS-FHT?view=index : 24. Apr. 2025), Aufnahme 16 von 3506; Ohio Historical Society (Columbus, Ohio).
Image Group Number: 004058927

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