LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

25073

1. PLACE OF DEATH
County Ray — Registration District No. 915 — File No.
Township Knox Fells — Primary Registration District No. 6236 — Registered No. 8
City (No. , St. Ward)

2. FULL NAME Olen Millard Kincaid
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| Male | White | Single |

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 13 1899

| AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 23 | 9 | 7 | |

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray Co Mo.

10. NAME OF FATHER James M Kincaid

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ray Co Mo

12. MAIDEN NAME OF MOTHER Sarah A Russell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

INFORMANT (Address) Myrtle Kincaid Cowgill Mo

FILED Aug 20 1923 Mrs. G. W. Gaines REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 1923

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1923, to ✓, 19✓ that I last saw him alive on ✓, 19✓, and that death occurred, on the date stated above, at 8:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Fall of 190 feet in Coal mine. Body crushed.

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) ✓

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? ✓ DATE OF ✓
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? ✓

Aug 20 1923 (Signed) G W Gaines Coroner, M. D
(Address) Rayville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL |
|---|---|
| Kincaid Cemetery Ray Co | Aug 21 1923 |

| 20. UNDERTAKER | ADDRESS |
|---|---|
| Alspaugh & Cowley | Polo Mo. |

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., .....St. .....Ward

2. FULL NAME .....

(a) Residence. No..... St., .....Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. d

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
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that I last saw h..... alive on....., 19....., and
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....,

, 19 (Address)

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