

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

Do not use this space.

21707
2847

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Raw Primary Registration District No. _____
City Kansas City (No. St. Luke's Hospital) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Lillian Kincheloe
(a) Residence. No. 3430 Harrison St., 6 Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 31, 1894

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	34	5	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employed) _____
(c) Name of employer A.C. Provident Ass.

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

10. NAME OF FATHER George R. Kincheloe

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

12. MAIDEN NAME OF MOTHER Jessie Fitzsimmons

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

14. INFORMANT Louise Kincheloe
(Address) 3430 Harrison

15. FILED 6-29-29 M. M. Crum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28, 1929

17. I HEREBY CERTIFY, That I attended deceased from 6-11-29, 1929, to 6-28-29, 1929, that I last saw her alive on 6-28-29, 1929, and that death occurred, on the date stated above, at 10:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Auto Induration
5 1/2 (duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) Inflammatory Rheumatism
(duration) yrs. mos. 2 1/2 ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Lester B. Miller, M.D.

(Address) 1201 Kessler St. 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lebanon, Mo. DATE OF BURIAL June 30, 1929

20. UNDERTAKER D. W. Newsome's Sons ADDRESS 2116 E. 9th St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH—THIS IS A PERMANENT RECORD

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Mr. Leslie B. Miller
1201 Quetta Bldg.
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