

DEC 0 FEB 20 1939

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

1133

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 355
(b) Township Kaw Primary Registration District No. 1002 Registered No. 146
(c) City Kansas City, Mo. (d) Street No. Research Hospital, K.C. Mo. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 523 Benjamin F. Kincaid

(a) Residence, No. Polo, Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 5th, 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 8 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri13. NAME William Kincaid14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri15. MAIDEN NAME Elizabeth Thompson,16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri17. INFORMANT Susie Kincaid
(ADDRESS) Polo, Missouri18. BURIAL, CREMATION, OR REMOVAL
PLACE Cowgill, Missouri DATE Jan. 13th, 193919. FUNERAL DIRECTOR (NAME) Mrs. C.L. Forster
(ADDRESS) Kansas City, Missouri.20. FILED Jan 21 1939 B.M. Brown
Local Registrar.21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 11, 1939

22. I HEREBY CERTIFY, that I attended deceased from Dec. 29, 1938 to Jan 11, 1939
I last saw him alive on Jan 11, 1939. Death is said to have occurred on the date stated above, at 8:39 P.M.

The principal cause of death and related causes of importance were as follows:

Uræmia

Date of onset

Other contributory causes of importance:
Hypertrophy of Prostate
Hydrothorax
Hydro-nephrosis
Multiple abscesses (right kidney)
Arterial Hypertension
Name of operation None Date of operation None
What test confirmed diagnosis? Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Sail K. Ferris, M. D.
(Address) 934 W. 44th St., Kansas City, Mo.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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1133
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township..... Primary Registration District No. 1002 Registered No.....
 (c) City K.C. (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Benjamin F Kincaid

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|--|---|
| 3. SEX <u>M</u> | 4. COLOR OR RACE <u>W</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>5-5-1861</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>5-5-1891</u> | | |
| 7. AGE | YEARS <u>77</u> | MONTHS <u>8</u> |
| | DAYS <u>6</u> | IF LESS than 1 day, _____ hrs. or _____ min. |
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. | |
| | 9. Industry or business in which work was done, as saw mill, bank, etc. | |
| | 10. Date deceased last worked at this occupation (month and year) | 11. Total time (years) spent in this occupation |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) | | |
| FATHER | 13. NAME | |
| | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) | |
| MOTHER | 15. MAIDEN NAME | |
| | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) | |
| 17. INFORMANT (ADDRESS) | | |
| 18. BURIAL, CREMATION, OR REMOVAL | | |
| PLACE | DATE | |
| 19. FUNERAL DIRECTOR (ADDRESS) | | |
| 20. FILED <u>Jan 12 1939</u> <u>M. M. Crave</u> Local Registrar | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-11-1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

| | |
|--|---------------|
| | Date of onset |
| | |

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19____
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify Carl R. Ferris, M. D.
 (Signed)..... (Address) K.C.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

