

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39492

State File No.

Registrar's No.

FILED JAN 5 1945

318

Primary Registration District No.

1003

11196

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Georgetown Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis
(c) City or town St. Louis 25-17
(If outside city or town limits, write "RURAL")
(d) Street No. 1630 1/2 Franklin
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Clifton Kincaid

(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26
year 1944 hour 9 minute 30 P M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Black
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased: Oct (Month) 1891 (Year)

Immediate cause of death: Coronary Thrombosis
Duration _____

8. AGE: Years 53 Months _____ Days _____ If less than one day
hr. _____ min. _____

Due to _____
Due to _____

9. Birthplace: _____ (City, town, or county) Miss! (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 9/1/44

10. Usual occupation Laborer

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____ Underline the cause to which death should be charged statistically.

12. Name Wm. Kincaid

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant Thomas F. Callahan

(b) Address 1300 Clark

17. (a) Burial (Burial, cremation, or removal) (b) Date thereat 12/29/44 (Month) (Day) (Year)

(c) Place: burial or cremation Potters Field

18. (a) Signature of funeral director Peoples Und CO

(b) Address 3100 FRANKLIN AVE

19. (a) DEC 29 1944 (Date received local registrar) J. F. Brebeck (Registrar's signature)

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 town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury 3

23. Signature Clifton Kincaid (M. D. or other) Clifton Kincaid

Address Georgetown Hospital Date signed 12/26/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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, fact should be so stated above.