

FILED AUG 7 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1910

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration facility.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days
(Specify whether)

In this community 43 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County B. C.

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3203-A Utah Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME KINCAID, Marion A.

3. (b) If veteran, name war World I

3. (c) Social Security No. 497 09 6976

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ireda Kincaid

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased May 14 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

52	2	16	hr. min.
----	---	----	----------

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business --

12. Name William Kincaid

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

14. Maiden name Clara Lathe

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

16. (a) Informant Clinical Clerk, Vet. Adm. Fac.

(b) Address Jefferson Barracks, Mo.

17. (a) Burial (b) Date thereof 8-2-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park.

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) 8-4-1945 (b) C. S. M. Gansard
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 1945 hour 1:05 minute A. M.

21. I hereby certify that I attended the deceased from July 19, 1945, to July 30, 1945;
that I last saw him alive on July 30, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death TUBERCULOUS MENINGITIS.

Due to --

Due to --

Other conditions Tuberculosis of lung & adrenal. Unk.
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operation

Of autopsy See cause of death.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(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 _____

23. Signature E. V. EDWARDS, LT. COL. (M. D. or other) M. C.
Clinical Director.
Address Vet. Adm. Fac. JEFF. BARR. MO. Date signed 7/30/45

Duration

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

JUL 28 1945

OCT 1 1945

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 Bradford A. Miles

Licensed Embalmer No. 2906

P. O. Address University City, Mo.

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.