S. No. 2
M—8-43
5-17-39
P I X37823

3

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4941

FILED FEB 28 1946

Registration District No. 70 Primary Registration District No. 5282 Registrar's No. 14

1. PLACE OF DEATH:

(a) County Clark

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

(c) Name of hospital or institution: Mrs Hom Sp

(If not in hospital or institution, write street number or location)

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

In this community life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clark 23

(c) City or town Kahoka - Rural (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Charles Oliver Kinkeade

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced 2 widowed

6. (b) Name of husband or wife Loumittey Kinkeade

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

7. Birth date of deceased Oct. 24 - ~~1946~~ 1858 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
88	2	17	hr. min.

9. Birthplace (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Wm Kinkeade
13. Birthplace (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Sarah Smith
15. Birthplace (City, town, or county) 7 (State or foreign country)

16. (a) Informant Mrs Marion Armstrong

(b) Address Kahoka Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20-1946 (Month) (Day) (Year)

(c) Place: burial or cremation Prairie Church

18. (a) Signature of funeral director Lutting Lee

(b) Address Kahoka Mo.

19. (a) 1/17 46 (Date received local registrar) (b) J R Bridges (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 17 year 1946 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1-10, 1946, to 1-17-, 1946 that I last saw him alive on 1-17-, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 830

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury 2

23. Signature S H Fanning (M. D. or other) DO

Address Kahoka Date signed 1-18-46

(Licensed Embalmer's Statement on Reverse Side)

1946 - 1 - 17
88 - 2 - 17

46
80
1858

RECEIVED
District Health Officer No. 10
District File Number 2-46-237
Date Filed FEB 25 1946

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 Olin L. Sutting

Licensed Embalmer No. 290 S

P. O. Address Lunay 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.