

No. 2
12-45
-17-39
X47070

FILED MAR 6 1947

State File No. _____

Registration District No. 37

Primary Registration District No. 4049

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Centralia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Centralia
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Colvin D. Kincaid

3. (b) If veteran, name war ✓ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced 2 divorced

6. (b) Name of husband or wife John A. Kincaid 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased April - 27 - 1879
(Month) (Day) (Year)

8. AGE: Years 87 Months 7 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

MOTHER FATHER

11. Industry or business _____
12. Name William Dinkindie

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

14. Maiden name Anna Dinkindie
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fountain
(b) Address Centralia, Mo.

17. (a) Buried (b) Date thereof Feb 17 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Mo.

18. (a) Signature of funeral director Geo. J. J. J.
(b) Address Centralia, Mo.

19. (a) Feb. 25 - 1947 (b) Maud McBride
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15 year 1947 hour 7 minute 20 A.M.

21. I hereby certify that I attended the deceased from August 3, 1945, to Feb. 14, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction Duration about 6 weeks

Due to Suspected carcinoma of colon

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations 46E Of autopsy _____
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 D

23. Signature Leopold Sachse (M. D. or other) M.D.
Address Centralia, Mo. Date signed 2-24-47

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

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RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 2-5-47

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 Wm Jernigan
Licensed Embalmer No. 4270
P. O. Address Centralia, 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.