

FILED DEC 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40928
Registrar's No. 5056

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) 25 yrs.		d. STREET ADDRESS (If rural, give location) 4235 Locust Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4235 Locust Street			

3. NAME OF DECEASED (Type or Print) a. (First) Omar b. (Middle) Walker c. (Last) PINKSTON			4. DATE OF DEATH (Month) (Day) (Year) Nov - 29 - 50		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH -	9. AGE (In years last birthday) 75	10. UNDER 1 YEAR Months Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Army Officer, MD		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Yondle Pinkston	13b. MOTHER'S MAIDEN NAME Betty R. Robinson	14. NAME OF HUSBAND OR WIFE Mel Pinkston
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. R.L. Cole, 3623 Michigan, KC, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary		INTERVAL BETWEEN ONSET AND DEATH 587^h
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Patly Degeneration of Liver		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) natural	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Hugh H. Owens (Degree or title) <i>Hugh H. Owens, M.D.</i>	23b. ADDRESS 1034 Burt's Bldg	23c. DATE SIGNED 11-30-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-1-50	24c. NAME OF CEMETERY OR CREMATORY National Cemetery
24d. LOCATION (City, town, or county) (State) Ft. Leavenworth, Kansas		

DATE REC'D BY LOCAL REG. 11-30-50	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilley-Eylar, Kansas City, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 5 1954

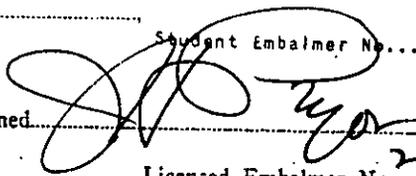
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed.....



Student Embalmer No.....

Licensed Embalmer No. 2989

P. O. Address. KC

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.