

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29353

FILED OCT 3 1951

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

BIRTH NO. _____		REG. DIST. NO. <u>4</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>260</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Searles</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Merthville</u>		c. LENGTH OF STAY (In this place) <u>4 da</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Adair</u>		0 95 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>West of Memphis</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JESSIE</u>		b. (Middle) <u>MAE</u>		c. (Last) <u>Kincaid</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 22 51</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>Feb 4 1874</u>	
9. AGE (In years last birthday) <u>77</u>		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 1 HRS. Hours _____ Min. _____		9. AGE (In years last birthday) <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Adair Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Kincaid</u>			13b. MOTHER'S MAIDEN NAME <u>Susan Holt</u>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>John Kincaid</u>		ADDRESS <u>Merthville</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Chronic Diffuse Glomerulo Nephritis ?</u> <u>Auricular Fibrillation ?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>332X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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)		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 <u>Sept 20</u> , 19 <u>51</u> , to <u>Sept 22</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Sept 22</u> , 19 <u>51</u> , and that death occurred at <u>5:35A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>R. T. Rhoads D.O.</u>		(Degree or title)		23b. ADDRESS <u>Merthville, Mo</u>		23c. DATE SIGNED <u>9-23-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Oct 26 51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Camp Ground</u>		24d. LOCATION (City, town, or county) (State) <u>Adair Co Mo</u>	
DATE REC'D BY LOCAL REG. <u>9-27-51</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Smith</u>			

Date Received: OCT 2 1951  
DISTRICT HEALTH OFFICE #2  
District File Number 10-57175-8  
Date Filed: OCT 2 1951

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4258

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.