

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42114**

DEC 23 1952
BIRTH NO. _____ REG. DIST. NO. **138** PRIMARY REG. DIST. NO. **5823** Registrar's No. **125**

0430

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

1. PLACE OF DEATH a. COUNTY HICKORY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE MO b. COUNTY HICKORY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Greene		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Greene 0430	
c. LENGTH OF STAY (In this place) 70YRS		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Pearl b. (Middle) Pansy c. (Last) Kincaid			4. DATE OF DEATH (Month) (Day) (Year) 12-14-52		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W.	8. DATE OF BIRTH July-31-1880	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 4 Days 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hickory Co. O	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Fountain H. Pitts	13b. MOTHER'S MAIDEN NAME ANNIE E. Dennis	14. NAME OF HUSBAND OR WIFE Artie A. Kincaid
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mr. Holly F. Kincaid	ADDRESS Pittsburg
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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		INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 332 X
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 Dec 2, 1952, to Dec 14, 1952, that I last saw the deceased alive on Dec 12, 1952, and that death occurred at 12:30 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. Merino M.D.	23b. ADDRESS Hermitage Mo	23c. DATE SIGNED 12-16-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-15-52	24c. NAME OF CEMETERY OR CREMATORY Antioch cem.	24d. LOCATION (City, town, or county) (State) Hickory Co MO
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DATE REC'D BY LOCAL REG. 12-17-52	REGISTRAR'S SIGNATURE Mary Johnson 464-0	25. FUNERAL DIRECTOR'S SIGNATURE Vaughan-Rear	ADDRESS Urban Mo
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MAY 11 1971

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 Allen W. Vaughan

Licensed Embalmer No. 4156

P. O. Address Urban, 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.