

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9922

State File No. 1601

FILED APR 9 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1601

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) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MARTIN CITY 7000	
c. LENGTH OF STAY (in this place) 5 DAYS		d. STREET ADDRESS (If rural, give location) IN TOWN	
d. FULL NAME OF HOSPITAL OR INSTITUTION RESEARCH HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) WYATT c. (Last) KINCAID			4. DATE OF DEATH (Month) (Day) (Year) 3 20 53			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 1	8. DATE OF BIRTH 3-22-82	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY GRADE SCHOOL		11. BIRTHPLACE (City and State or Foreign Country) GOVER MO. U		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME THOMAS KINCAID		13b. MOTHER'S MAIDEN NAME FLORA GARTIN		14. NAME OF HUSBAND OR WIFE LOTTIE KINCAID	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ✓		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JESSER KINCAID MARTIN CITY, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized peritonitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Perforated duodenal ulcer DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 5411
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **As Pathologist**, 19**53**, that I last saw the deceased alive on **March 20, 1953**, and that death occurred at **8:15 AM**, from the causes and on the date stated above.

23a. SIGNATURE Robert K. B. Allbaugh, M.D. (Degree or title)	23b. ADDRESS 2300 Holmes, K.C., Mo.	23c. DATE SIGNED March 20, 53
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24a. BURIAL CREMATION REMOVAL (Specify)	24b. DATE 3/22/53	24c. NAME OF CEMETERY OR CREMATORY CLINTON CEM.	24d. LOCATION (City, town, or county) (State) CLINTON MO
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DATE REC'D BY LOCAL REG. 3-20-53	REGISTRAR'S SIGNATURE Genevieve Smith	FUNERAL DIRECTOR'S SIGNATURE E. George Jones	ADDRESS Belton Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Sterling E. Goodard

Licensed Embalmer No. *4911*

P. O. Address *Grandview 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.