

FILED OCT 23 1956

STANDARD CERTIFICATE OF DEATH

State File No. 33523

BIRTH NO. REG. DIST. NO. 98 PRIMARY REG. DIST. NO. 4165 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY Daviess 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Daviess

b. CITY (If outside corporate limits, write RURAL and give township) Gallatin c. LENGTH OF STAY (If in this place) 10 Days c. CITY OR TOWN Altamont d. Is Residence within limits of a city or incorporated town? Yes X No

d. FULL NAME OF HOSPITAL OR INSTITUTION Sullivan Rest Home e. STREET ADDRESS (If rural, give location) 0310

3. NAME OF DECEASED a. (First) John b. (Middle) Ambrose c. (Last) Kinkade 4. DATE OF DEATH (Month) (Day) (Year) October 10 1956

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Jan. 13, 1877 9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner 11. BIRTHPLACE (City and State or Foreign Country) Daviess Co., Missouri 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Eleazer Kinkade 13b. MOTHER'S MAIDEN NAME Rebecca Shatto 14. NAME OF HUSBAND OR WIFE Amie Kinkade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Mrs. Amie Kinkade, Altamont, Mo. ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Cerebral Thrombosis. INTERVAL BETWEEN ONSET AND DEATH 3 weeks. ANTECEDENT CAUSES DUE TO (b) Arterio Sclerosis. Years DUE TO (c) II. 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 NO X

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) m. 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 20th 1956, to Oct 10, 1956 that I last saw the deceased alive on Oct 9th, 1956 and that death occurred at 12:05 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Fred W. Wilson MD 23b. ADDRESS Winston, Mo. 23c. DATE SIGNED Oct 12, 56

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 10-12-56 24c. NAME OF CEMETERY OR CREMATORY Mt. Ayr Cemetery 24d. LOCATION (City, town, or county) (State) Altamont, Missouri

DATE REC'D BY LOCAL REG. 10-17-56 REGISTRAR'S SIGNATURE Regina M. Engelhart 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hope Funeral Home, Gallatin, Mo.

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

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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.....  
Signature of Student Embalmer

Signed *L. O. Richesson*.....

Licensed Embalmer No. *3302*

P. O. Address *Dallatus*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.