

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

36204

STATE FILE NUMBER  
 4882

FILED NOV 5 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheran</b>		Length of stay in lb <b>1 day 7 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>4003 Marrell</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lindsey Olen Vinson</b>			4. DATE OF DEATH Month Day Year <b>October 19 1957</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26 1901</b>
9a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>Corp. Mgr. Hillman Sales Company</b>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years (birthday) F UNDER 1 YEAR Months Days I F UNDER 24 HRS. Hours Min. <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Bethany, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Wesley Vinson</b>	
13b. MOTHER'S MAIDEN NAME <b>Daisy Pearl Wilson</b>		14. NAME OF HUSBAND OR WIFE <b>Betty Inez Vinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>491-09-8436</b>	17. INFORMANT Address <b>Raytown, Missouri</b> <b>Jacquelin Jacobson 9704 E 81 st. St. Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Great pulmonary edema</b> DUE TO (b) <b>Coronary thrombosis with myocardial infarction</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>8 weeks</b> <b>1 year +</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>5-7-56</b> to <b>10-19-57</b> and last saw him alive on <b>10-14-57</b> Death occurred at <b>8:45</b> <b>A.M.</b> upon the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Herbert Shuey</b> (Degree or title) <b>M. D.</b>		22b. ADDRESS <b>3903 Brooklyn K.C. Mo.</b>	
22c. DATE SIGNED <b>10-21-57</b>		23a. BURIAL, CREMATION, (Specify)	
23b. DATE <b>10-22-1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Memorial Garden</b>	
23d. LOCATION (City, town, or county) (State) <b>Blue Ridge &amp; Gregory, K.C. Mo.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Floral Hills Memorial Chapels, K.C. Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>10-21-57</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Herbert Shuey

Dr. Herbert Shuey  
3903 Bruce Ridge

Wa 4-6493 - 2 pm -

Res 933E 772er

Hi-4-2852

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 *P. J. Nofsinger*  
Licensed Embalmer No. *5938*  
P. O. Address *P. O. No.*

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.

