

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005643
STATE FILE NUMBER
966

FILED MAR 13 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 966

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-57

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, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 417 Wallace		Length of stay in lb 30 yrs	d. STREET ADDRESS (If outside, give location) 417 Wallace Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE IRENE KINCAIDE			4. DATE OF DEATH Month Day Year February 20 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29 1882
9. AGE (In years last birthday) 75		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lindley Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Mack	13b. MOTHER'S MAIDEN NAME - Caywood
14. NAME OF HUSBAND OR WIFE Robert Kincaide (Dec)		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 Address Mrs Velma Hudson 1815 Overton Indep Mo		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Generalized arterio sclerosis DUE TO (c) Hypertensive cardio vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive cardio vascular disease with 1st degree decomp.	
INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 Dec 1954 , to Feb 20 1958 and last saw her alive on Dec 24 1957 Death occurred at 417 Wallace KC Mo on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Chas. E. Nickerson Jr. M.D.		22b. ADDRESS Independence Mo	22c. DATE SIGNED 2-21-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/22/58	23c. NAME OF CEMETERY OR CREMATORY Mt Washington Cemetery	23d. LOCATION (City, town, or country) (State) Kansas City Missouri
24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home Kansas City Mo.		25. DATE RECD. BY LOCAL REG. 2-22-58	26. REGISTRAR'S SIGNATURE Neva Minshall

All diseases in Part I must be causally related.
MEDICAL CERTIFICATION
Chas. E. Nickerson, Jr. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE



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 *Thomas A. Smith*

Licensed Embalmer No. *4954*

P. O. Address *J. C. Smith*

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.