

FILED MAR 24 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH58-010531  
STATE FILE NUMBERRegistration District No. 174 Primary Registration District No. 2035 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) LEHINGTON Memorial Hospital			Length of stay in lb <u>2 wks</u>		d. STREET ADDRESS <u>152 North 11th St.</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>F.</u> Last <u>Kinkead</u>				4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 8, 1879</u>		9. AGE (In years last birthday) <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Wellington, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James L. Kinkead</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Reed Thorp</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>2040</u>		17. INFORMANT <u>Miss Sue Kinkead, Kansas City, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic leukemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>		
Conditions, if any, which pose risk to above cause (a), stating the underlying cause last.							DUE TO (b) _____		
							DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							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.) <u>2</u>						
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 <u>1953</u> , to <u>Feb. 28, 1958</u> and last saw her alive on <u>Feb 27, 1958</u> Death occurred at <u>6:20 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Joseph M. D. Lexington Mo</u> (Degree or title)				22b. ADDRESS		22c. DATE SIGNED <u>3/11/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>March 2, 1958</u>		<u>Machpelah</u>		<u>Lexington, Missouri</u>			
24. FUNERAL DIRECTOR <u>James T. Tempel, Lexington, Missouri</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>3-15-58</u>		26. REGISTRAR'S SIGNATURE <u>Thomas E. Heston</u>		

(Licensed Embalmer's Statement on Reverse Side)

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Doctor, coroner, etc. must use any standard nomenclature in their reports. Symptoms must be stated. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.....  


Licensed Embalmer No. ....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.