

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011861

STATE FILE NUMBER 3429

FILED APR 15 1958

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis - 5 4336		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 09 DePaul Hosp.		Length of stay in lb 14 Yrs.	d. STREET ADDRESS 27 6225 a Cabanne Av.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE LAST WESLEY ROY KINCAID			4. DATE OF DEATH Month Day Year MAR. 22., 1958		
5. SEX M. 0	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1890	9. AGE (In years less birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith (retired)		10b. KIND OF BUSINESS OR INDUSTRY Larkin-Packer Co.	11. BIRTHPLACE (City and state or country) Washington, Mo. 0		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME J. William Kincaid		13b. MOTHER'S MAIDEN NAME Mary Elizabeth Hawkins		14. NAME OF HUSBAND OR WIFE Gertrude B. Kincaid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. _____	17. INFORMANT Address William H. Kincaid #20 Norine (24)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO (b) <i>Gen Arterio Sclerosis</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <i>Myocardial Infarction</i> 451*					INTERVAL BETWEEN ONSET AND DEATH 12 min Arterio
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 <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 _____ 1958, to _____ 1958 and last saw him alive on 3/22-58 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor or title) <i>W. H. Kincaid</i>			22b. ADDRESS 634 W. Grand Blvd		22c. DATE SIGNED 3/24-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar 26, 1958	23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) Desoto Missouri	
24. FUNERAL DIRECTOR Alexander & Sons, Inc. 6175 Delmar		ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 25 '58	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> S.P	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Dr. John Myers

Mo. Theatre Bldg.

0123888

7-6

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 *Custar W. [Signature]* .....

Licensed Embalmer No. *4329* .....  
P. O. Address *St. Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.