

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-026123

FILED JUL 22 1958

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 5628 Registrar's No. 114

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gasconade T.S.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Falcon</u> <u>6530</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Falcon</u>		Length of stay in lb <u>50 Yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Falcon</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> <sup>First</sup> <u>JACKSON</u> <sup>Middle</sup> <u>KINCHELOE</u> <sup>Last</sup>			4. DATE OF DEATH Month <u>July</u> , Day <u>6</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"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-1879</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>Agriculture</u>	9. AGE (In years last birthday) <u>78</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11a. BIRTHPLACE (City and state or country) <u>Laclede County Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>P.E. Kincheloe</u>		13b. MOTHER'S MAIDEN NAME <u>Sally J. Haizlip</u>	
14. NAME OF HUSBAND OR WIFE <u>Florence Kincheloe</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>None.</u>		17. INFORMANT <u>Mrs. Harvey Percy Falcon, Mo.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Probable duodenal ulcer</u> DUE TO (c) <u>Malnutrition</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Patient needed many things checked, but refused.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u> <u>2 years.</u>
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 <u>1954</u> to <u>July 2, 58</u> and last saw <sup>her</sup> him alive on <u>July 2, 58</u> Death occurred at <u>8:00 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (D, tree or title) <u>W. Carrington, M.D.</u>		22b. ADDRESS <u>Libanon, Mo.</u>	
22c. DATE SIGNED <u>7-8-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>7/9/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hew Home Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Laclede County Missouri</u>		24. FUNERAL DIRECTOR <u>S. R. Palmer Libanon mo.</u> ADDRESS	
25. DATE RECD. BY LOCAL REG. <u>7-12-1958</u>		26. REGISTRAR'S SIGNATURE <u>Hella L. May</u>	

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.

Received JUL 21 1958  
Laclede County Health Unit.  
File No. 114  
Date Filed JUL 21 1958

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 J. P. Palmer

Licensed Embalmer No. 2208

P. O. Address Channon

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.