

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031827
STATE FILE NUMBER

OCT 14 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1075

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph Mo</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Trenton e 40.2</i>
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>State Hospital</i>		Length of stay in 1b <i>3 months</i>	d. STREET ADDRESS (If outside, give location) <i>601 Munroe</i>
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Kincaid</i> Last <i>Kincaid</i>			4. DATE OF DEATH Month <i>Oct</i> Day <i>4</i> Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 6 1872</i>
9. AGE (In years and birthday) <i>86</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <i>Lab. Tech.</i>	11. BIRTH PLACE (City and state or country) <i>Trenton Mo</i>
12. CITIZEN OF WHAT COUNTRY? <i>America</i>		13. FATHER'S NAME <i>George Kincaid</i>	
13b. MOTHER'S MAIDEN NAME <i>Sarah Rossor</i>		14. NAME OF HUSBAND OR WIFE <i>Sarah R. Kincaid</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <i>unknown</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>Records State Hospital #2, St. Joseph, Mo</i>		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) <i>Chronic myocarditis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<i>4222</i>
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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 <i>Oct 4-58</i> to <i>Oct 4-58</i> and last saw him alive on <i>Oct 4-58</i> Death occurred at <i>4:40 PM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. P. Price M.D.</i> (Degree or title)		22b. ADDRESS <i>State Hospital #2</i>	
		22c. DATE SIGNED <i>Oct 4-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>Oct 4, 1958</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Maple Grove</i>		23d. LOCATION (City, town, or county) (State) <i>Trenton, Missouri</i>	
24. FUNERAL DIRECTOR <i>Heaton-Bowman</i> ADDRESS <i>St. Joseph, Mo</i>		25. DATE RECD. BY LOCAL REG. <i>Oct 4, 1958</i>	
		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>	

(Licensed Embalmer's Statement of Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DR. R. P. PRICE

gwh

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 *John W. Herrick Jr.*
Licensed Embalmer No. *4848*
P. O. Address *K. C. 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.