

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033060

STATE FILE NUMBER

FILED OCT 1 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4318

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		Length of stay in lb <b>60 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>3913 Morrell</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Achill</b> Last <b>Vinckier</b>			4. DATE OF DEATH Month <b>9</b> Day <b>6</b> Year <b>58</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/8/1881</b>		9. AGE (In years last birthday) <b>77</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>McPike Drug Co.</b>		11. BIRTHPLACE (City and state or country) <b>Belgium</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13a. FATHER'S NAME <b>Henry Vinckier</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Frances Vinckier</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>486-26-0358</b>		17. INFORMANT Address <b>Frances Vinckier 3913 Morrell, Kansas City.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Gastro Enteritis &amp; Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Acute + Chronic Nephritis</b> DUE TO (c) <b>Carcinoma of Prostate</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>177 x 0</b>						INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b> <b>2 wks</b> <b>2 yrs</b>		
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 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 <b>7-2-56</b> to <b>9-6-58</b> and last saw her alive on <b>9-5-58</b> Death occurred at <b>7:20 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Robert L. Ward M.D.</b>				22b. ADDRESS <b>4126 St. John St. Mo.</b>		22c. DATE SIGNED <b>9-6-58</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-9-58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>		
24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>9-9-58</b>		26. REGISTRAR'S SIGNATURE <b>neva marshall</b>		

Cause of death, etc.: most use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Robert L. Ward

No. 100-388-1000  
 State of Michigan  
 Department of Health  
 Bureau of Health Services  
 Lansing, Michigan  
 License No. 4954  
 P. O. Address R. P. M.



**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. Seal*

Licensed Embalmer No. *4954*  
 P. O. Address *R. P. M.*

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.