

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001377

STATE FILE NUMBER

FILED JAN 21 1959 Registration District No. 149 Primary Registration District No. 002 Registrar's No. 143

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Joseph Hosp			Length of stay in <u>60 Days</u>	d. STREET ADDRESS 8233 Tracy			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FINIS E. KINKEAD				4. DATE OF DEATH Month Day Year Jan 8 1959				
5. SEX Male <input type="checkbox"/>	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 27 1886		9. AGE (In years last birthday) 72		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Wellington Mo		12. CITIZEN OF WHAT COUNTRY? Usa	
13. FATHER'S NAME Ried Kinkead				14. MOTHER'S MAIDEN NAME Jennie Porter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Zoneta Kinkead 8233 Tracy K. C. Mo				
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>DUODENAL &amp; MASSIVE HEMORRAGE</u> <u>ULCER</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</u>	
Conditions, if any, which gave rise 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) 5							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
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 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>1954</u> to <u>1-8-59</u> and last saw <sup>her</sup> alive on <u>1-7-59</u> Death occurred at <u>8:50 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>B. C. Swistgard M.D.</u>				22b. ADDRESS <u>6741 Prosper K.C.</u>		22c. DATE SIGNED <u>1-8-59</u>		
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <u>Jan 10 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mecklin Cem</u>		23d. LOCATION (City, town, or county) (State) <u>R. F. D. Oak Grove Mo</u>			
24. FUNERAL DIRECTOR <u>Lebb Funeral Home Oak Grove Mo</u>			25. DATE RECD. BY LOCAL REG. <u>1-9-59</u>		25. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>			

(Licensed Embalmer's Statement on Reverse Side)

In, self, offic, vice  
 00 56  
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 P. C. Swistgard

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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 *William Free*

Licensed Embalmer No. *47*

P. O. Address *Blue Springs*

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.