

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013344

FILED APR 27 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1799

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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, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> 3678 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. Luke's Hospital</b>		Length of stay in 1b —	d. STREET ADDRESS (If outside, give location) <b>304 W. 44th</b> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward H. Hinze</b>			4. DATE OF DEATH Month Day Year <b>April 7 1959</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>2-11-1886</b>		9. AGE (In years last birthday) <b>73</b> IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOSPITAL EMPLOYEE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>DIETARY</b>	11. BIRTHPLACE (City and state or country) <b>BELLEVILLE, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
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13a. FATHER'S NAME <b>FREDRICK C. HINZE</b>	13b. MOTHER'S MAIDEN NAME <b>CAROLINE ROHM</b>	14. NAME OF HUSBAND OR WIFE <b>JANEY McSPADDEN</b>
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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. —	17. INFORMANT <b>MRS. JANEY HINZE</b>	Address <b>304 W. 44th</b>
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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>Lymphogenous Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Mo.</b>
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)		19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input 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.)
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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
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21. I attended the deceased from Death occurred at <b>9:00 am.</b> <b>1950</b> to <b>1959 Apr 7</b> and last saw <sup>her</sup> him alive on <b>Apr 7, 1959</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>M. G. Barry MD.</b>	(Degree or title) <b>MD.</b>	22b. ADDRESS <b>315 Nichols Rd Kansas City 12, Mo</b>	22c. DATE SIGNED <b>Apr 7, 1959</b>
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23a. BURIAL CREMATION, REINTERMENT (Specify) <b>BURIAL</b>	23b. DATE <b>4-9-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SHARON CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>DREXEL MISSOURI</b>
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24. FUNERAL DIRECTOR <b>Rayan Funeral Home Drexel, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>4-9-59</b>	26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>
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M. G. Barry USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

VS  
FEB 1 6 13 PM

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 ..... *Donald E. White* .....

Licensed Embalmer No. .... *4956* .....

P. O. Address: *Washington* .....

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.