Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-013383

STATE FILE NUMBER

FILED MAY 13 1959

Registration District No. 141 Primary Registration District No. 1002 Registrar's No. 1592

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN: Kansas City, Mo — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: St. Mary's Hosp — Length of stay in 1b: 42 YEARS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1531 East 48th St. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Reed Middle: WYATT Last: Kincaid

4. DATE OF DEATH: Month: 4 Day: 20 Year: 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARITAL STATUS: MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 12 3 1898

9. AGE (In years): 60 — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Route Salesman Aines Dairy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Polo, Mo.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: Lewin Kincaid

13b. MOTHER'S MAIDEN NAME: Tina M. ~~Synyder~~ Snyder

14. NAME OF HUSBAND OR WIFE: Pauline M. Kincaid

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 487 05 9586

17. INFORMANT: Pauline M Kincaid Address: 1531 East 48 Th Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): arteri sclerosis
DUE TO (c): 4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Myocardial failure and pulmonary edema

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

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 [ ] NOT WHILE AT WORK [ ]

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 1939 to April 20, 59 and last saw her/him alive on April 18, 59
Death occurred at ~~County St Mary Hosp~~ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Merwin J. Rumold M.D.

22b. ADDRESS: Bennett Time Bldg

22c. DATE SIGNED: April 30, 59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 4 22 59

23c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah

23d. LOCATION (City, town, or county) (State): Kansas City, Mo.

24. FUNERAL DIRECTOR: D. W. Newcomer's Sons — **ADDRESS**: K. C. Mo.

25. DATE RECD. BY LOCAL REG.: 4-21-59

26. REGISTRAR'S SIGNATURE: Neva Meinshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Merwin J. Rumold

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student ..... Signed .....

Signature of Student Embalmer

Licensed Embalmer No. 4491

P. O. Address Kansas Ci

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.