Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-017758
STATE FILE NUMBER

FILED MAY 29 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2272

1. PLACE OF DEATH a. COUNTY: Jackson	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Kansas City — Inside Limits: Yes XX No ☐	c. CITY OR TOWN: Kansas City — Inside Limits: Yes XX No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Research Hosp. — Length of stay in 1b: 30 YRS	d. STREET ADDRESS (If outside, give location): 525 Armour Blvd. Apt. 819 — Reside on Farm: Yes ☐ No XX

3. NAME OF DECEASED (Type or print) First: George	Middle: E.	Last: Hincke	4. DATE OF DEATH Month: May Day: 5 Year: 1959	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐	8. DATE OF BIRTH: DEC 24. 1874	9. AGE (In years last birthday): ~~78~~ 84 — 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): RETIRED PRES. OF ISMERT	10b. KIND OF BUSINESS OR INDUSTRY: AND HINCKE MILL. CO.	11. BIRTHPLACE (City and state or country): PINCKENVILLE, ILL	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME: GEORGE E. HINCKE	13b. MOTHER'S MAIDEN NAME: PAULINA WALTERS	14. NAME OF HUSBAND OR WIFE: ANNA CATHERINE HINCKE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: NONE	17. INFORMANT Address: JOHN HINCKE WASHINGTON D. C.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	10 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hypertension	5 yrs
DUE TO (c)	Arterio-sclerosis	5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331x

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 1954, to May 5-59 and last saw her/him alive on May 4-59
Death occurred at Research Hospital K.C. Mo. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Glenn C Carbaugh M.D.	22b. ADDRESS: 2004 Bryant Bldg K.C. Mo	22c. DATE SIGNED: May 5-59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL	23b. DATE: MAY 7 1959	23c. NAME OF CEMETERY OR CREMATORY: CITY CEM.	23d. LOCATION (City, town, or county) (State): PINCKENVILLE, ILL
24. FUNERAL DIRECTOR ADDRESS: D.W. Newcomers Sons Kansas City, Mo.	25. DATE RECD. BY LOCAL REG.: 5-6-59	26. REGISTRAR'S SIGNATURE: Neva Minshall	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Glenn C. Carbaugh

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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 embalme

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

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Albert L. Savage

Licensed Embalmer No. 4812

P. O. Address Kansas City

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.