

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 6 2 8

FILED VS DEC 23 1959

Primary Registration District No.

Registrar's No. 211328

STATE FILE NUMBER

INDEXED

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 Days	c. CITY OR TOWN Kingston Twp.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)
3. NAME OF DECEASED (Type or print)		First Middle Last	4. DATE OF DEATH
Walter Andrew Kincaid			Month Day Year Dec. 2, 1959

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1881	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Rented Farm	11. BIRTHPLACE (City and state or country) Wash. County, Mo.	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME William Kincaid		13b. MOTHER'S MAIDEN NAME Leonia Coleman		14. NAME OF HUSBAND OR WIFE Julia 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. None	17. INFORMANT William Kincaid, Cadet Rt.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Uremia</i>		<i>6 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Urinary obstruction</i>	<i>6 days</i>
	DUE TO (c) <i>Benign prostatic hypertrophy 610+</i>	<i>3 months</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Paralytic ileus</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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 <i>November 28, 1959</i> to <i>December 2, 1959</i> and last saw <i>her</i> ^{him} alive on <i>December 2, 1959</i> Death occurred at <i>145</i> <i>pm</i> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <i>John T. Lawton, M.D.</i>	22b. ADDRESS <i>634 N. Grand Blvd.</i>	22c. DATE SIGNED <i>Dec 2, 1959</i>
23a. BURIAL, CREMATION, REINTERMENT (Specify) <i>Burial</i>	23b. DATE <i>Dec. 5, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Joachim's Cemetery</i>
24. FUNERAL DIRECTOR ADDRESS <i>Arthur W. Smith, Potosi, Mo.</i>		23d. LOCATION (City, town, or county) (State) <i>Old Mines Mo.</i>

25. DATE RECD. BY LOCAL REG. <i>DEC 5 1959</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *[Handwritten Signature]*

Licensed Embalmer No. 4158

P. O. Address Potosi

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.