

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 20 1960

-60-034971

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4556 STATE FILE NUMBER

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		Length of stay in lb 73 yrs	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 Barton Nurs.Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 310 West 48th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LOUISE Middle LYDIA Last PINKARD			4. DATE OF DEATH Month 9 Day 3 Year 60			
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5. SEX Fe	6. COLOR OR RACE Wh	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-29-80	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Associate	10b. KIND OF BUSINESS OR INDUSTRY Ret. Dry Goods	11. BIRTHPLACE (City and state or country) Jefferson City, Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Jouis H. Karges	13b. MOTHER'S MAIDEN NAME Margaret Schott	14. NAME OF HUSBAND OR WIFE Wm. C. Pinkard
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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) No	16. SOCIAL SECURITY NO. 486-01-7585A	17. INFORMANT Address Mrs. Eliz. Von Seggern, West Point, Neb
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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) Brachapneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	6 years
	DUE TO (c) Generalized Arteriosclerosis	10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture of Right Hip 1966		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown

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 August 1 1944 to Sept. 3 1960 and last saw her Sept. 2 1960 alive on Sept. 2 1960
Death occurred at 3:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Arnold E. MacIntosh M.D.		22b. ADDRESS 4620 Nichols Parkway	22c. DATE SIGNED 9/4/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 9-6-60	23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory	23d. LOCATION (City, town, or county) (State) Kansas City Mo.

24. FUNERAL DIRECTOR Wagner Funeral Home, K. C. Mo.	25. DATE RECD. BY LOCAL REG. 9-6-60	26. REGISTRAR'S SIGNATURE H. L. Dwyer
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Florence E.

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 Alvin R. Hausch

Licensed Embalmer No. 4159

P. O. Address Kaunawa

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.