

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 23 1961

-60-048751  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6603

DEED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>11 years</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6424 Montgall</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6424 Montgall</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>B</u> Last <u>Kincaid</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 22, 1920</u>		9. AGE (last birthday) <u>90</u>	
						IF UNDER 1 YEAR		IF UNDER 24 HR	
						Months		Days	
						Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Cameron, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Abram Beeler</u>			13b. MOTHER'S MAIDEN NAME <u>Rebecca Majors</u>			14. NAME OF HUSBAND OR WIFE <u>Ralph R. Kincaid</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>LENA M. SMITH</u>		Address <u>6424 MONTGALL</u>			
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) <u>PULMONARY EMBOLISM</u>								<u>10 MIN</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>CEREBRAL HEMORRHAGE</u>						<u>2 weeks</u>	
		DUE TO (c) <u>ATHEROSCLEROSIS</u>						<u>UN KNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>MYOCARDIAL DECOMPENSATION</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <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 <u>12-27-58</u> to <u>12-29-60</u> and last saw her <sup>her</sup> alive on <u>12-29-60</u> Death occurred at <u>7 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>James E. Williams D.D.</u>				22b. ADDRESS <u>4233 BLUE RIDGE KENNO</u>				22c. DATE SIGNED <u>12-30-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>Dec 31, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Crematory</u>		23d. LOCATION (City, town, or county) <u>Kansas City Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Muehlebach Funer Home</u>		ADDRESS <u>6800 Troost</u>		25. DATE RECD. BY LOCAL REG. <u>12-30-60</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Dreyer</u>			

DOCUMENT

BY AFFIDAVIT OF James E. Williams MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. T. Crowell

Licensed Embalmer No. 490

P. O. Address H. E. W.

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