

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 23 1967

-60-048822

6561

STATE FILE NUMBER

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

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 5 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 4520 Main Street			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4520 Main Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First THOMAS Middle WILLIAM Last SINCLAIR				4. DATE OF DEATH Month December Day 25 Year 1960									
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 6/4/1904		9. AGE (last birthday) 56		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) Hamilton, Ontario		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME Thomas H. Sinclair				13b. MOTHER'S MAIDEN NAME Margaret Dawson				14. NAME OF HUSBAND OR WIFE Elizabeth Sinclair					
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. 382-05-7116		17. INFORMANT Elizabeth Sinclair, 4520 Main St.							
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) Rupture of Esophageal Varices										1 hour			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cirrhosis of the liver										1 yr.			
DUE TO (c) Alcoholism Chronic													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								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					
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 Dec. 1959 to Dec 25, 1960 and last saw him alive on Dec 25, 1960 Death occurred at 6:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Olto W. Theel M.D.						22b. ADDRESS 4301 Main St. KCMo			22c. DATE SIGNED 12-23-60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 28, 1960		23c. NAME OF CEMETERY OR PLACE OF BURIAL MEMORIAL PARK CEMETERY KANSAS CITY MISSOURI				23d. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo.				ADDRESS 1331 Brush Creek Blvd.		25. DATE RECD. BY LOCAL REG. 12-28-60		26. REGISTRAR'S SIGNATURE H-L. Dwyer					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

to **W. Theel**

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 Marvin D. Presto

Licensed Embalmer No. 5040

P. O. Address H.C. 2

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.