

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-51-007269
STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 29

AMENDED

FILED VS FEB 20 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Platte	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall		c. CITY OR TOWN Platte City	
Length of stay in 1b X 2 yrs		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Marshall State School & Hosp.		d. STREET ADDRESS (If outside, give location) 3rd & Main	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Victoria Sue Kindred			4. DATE OF DEATH Month Day Year X Feb. 15, 1961
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-24-48
9. AGE (last birthday) 12 yrs.		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) Patient		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Sioux Falls, S. D.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Floyd David Kindred	
13b. MOTHER'S MAIDEN NAME Juanita J. Kunkel		14. NAME OF HUSBAND OR WIFE -----	
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 Records of Marshall State School & Hosp., Marshall, Mo.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <input checked="" type="checkbox"/> IMMEDIATE CAUSE (a) Relational Bronchopneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Upper Resp. Infection DUE TO (c) ----- INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Birth-injured, cerebral palsied, chronic invalid			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. -----	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 4-1-1959 to 15 Feb 61 and last saw her alive on 15 Feb 61 Death occurred at 7:30 on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Edith M. ...	
22b. ADDRESS Marshall State School & Hosp., Marshall, Mo.		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-16-1961	23c. NAME OF CEMETERY OR CREMATORY Platte City Cemetery	23d. LOCATION (City, town, or county) (State) Platte City, Mo.
24. FUNERAL DIRECTOR Cambell-Lewis	ADDRESS Marshall, Mo.	25. DATE RECD. BY LOCAL REG. 2-16-'61	26. REGISTRAR'S SIGNATURE Carl G. Read

FEB 28 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____ Student-Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4709

P. O. Address _____

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.