

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008903

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 936

STATE FILE NUMBER

FILED VS MAR 13 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson		a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in lb 50 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7622 Main		d. STREET ADDRESS (If outside, give location) 7622 Main	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First Middle Last Edna Kincaid			Month Day Year Feb 20 1961			
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct 27, 1891	9. AGE (last birthday) 69	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Chadron Nebr	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Charles W. Huffback	13b. MOTHER'S MAIDEN NAME Anna Bohnsack	14. NAME OF HUSBAND OR WIFE Marvin Kincaid (Dec)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Blaine Kincaid 6430 Charlotte
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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) Strangulation		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	

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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Piece of meat caught in shoe
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20c. TIME OF INJURY Hour a.m. p.m. 2-2-61	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION Kansas City	COUNTY Jackson	STATE Mo
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21. I attended the deceased from _____ to _____ and last saw him/her alive on _____
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Rev. C. Kealho	22b. ADDRESS 6627 Park St Seward	22c. DATE SIGNED 2-2-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Feb. 22, 1961	23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory	23d. LOCATION (City, town, or county) (State) Kansas City Mo
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24. FUNERAL DIRECTOR Muehlebach	ADDRESS 6800 Troost	25. DATE RECD. BY LOCAL REG. 2-22-61	26. REGISTRAR'S SIGNATURE Ruth Long
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF
 C. Kealho 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 by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address N.C. 5mo

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.