

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026156

STATE FILE NUMBER

Registration District No. 270 Primary Registration District No. 3050 Registrar's No. 38

FILED AUG 2 1961

1. PLACE OF DEATH a. COUNTY <u>Remick</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Remick</u>	
b. CITY (If outside corporate limits give TOWNSHIP and OR TOWN <u>Carthersville</u>)		Length of stay in 1b	c. CITY OR TOWN <u>Carthersville</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>1303 Davis Ave</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1303 Davis Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Kincade</u> Last <u>Kincade</u>			4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</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>7-25-79</u>	9. AGE (last birthday) <u>82.</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>in their home Panatog Camp, Miss U.S.A.</u>		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Fred Harris</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>		13c. NAME OF HUSBAND OR WIFE <u>John Kincade</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFIRMANT <u>Flossie MacPherson</u> Address <u>Civille, Mo.</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 <u>3 days</u>
IMMEDIATE CAUSE (a) <u>Diabetic Acidosis</u>			
DUE TO (b) <u>Uncontrolled Diabetes Mellitus</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 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 checked="" 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 20 June 1961 to 19 July 1961 and last saw her alive on 7/19/61
Death occurred at 3 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Carthersville, Mo</u>	22c. DATE SIGNED <u>7/20/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-23-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Magnolia</u>	23d. LOCATION (City, town, or county) (State) <u>Carthersville, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>J. J. Smith, Fayette, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-23-1961</u>	26. REGISTRAR'S SIGNATURE <u>Jack W. Lipton</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. SHOULD READ
BY AFFIDAVIT OF

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 Jack Kelley

Licensed Embalmer No. 3788

P. O. Address Carthageville

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.