

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037017

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4895

STATE FILE NUMBER

FILED OCT 19 1961

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 20 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 Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1008 Oakley		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First IRWIN Middle ASHLEY Last KINCAID			4. DATE OF DEATH Month October Day 3 Year 1961		
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 12/29/1898	AGE (last birthday) 62-72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self Emp	11. BIRTHPLACE (City and state or country) Knoxville Mo	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Jojn C Kincaid		13b. MOTHER'S MAIDEN NAME Laura		14. NAME OF HUSBAND OR WIFE Oka Kincaid	
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.	17. INFORMANT Address Oka Kincaid 1008 Oakley K C Mo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ 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 (Enter only one disease condition given in PART I.) _____ 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					INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 Jan 9/28/61 to 10/2/61 and last saw her alive on 10/3/61 . 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) J. Montgomery M.D.			22b. ADDRESS 1332 Prof. Bldg Mo		22c. DATE SIGNED 10/3/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/5/61	23c. NAME OF CEMETERY OR CREMATORY Chapel Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Kansas		
24. FUNERAL DIRECTOR ADDRESS Sheil Fun ral Home Kansas City Mo			25. DATE RECD. BY LOCAL REG. 10-3-61	26. REGISTRAR'S SIGNATURE Ruth Long	

DATE AMENDED

10-12-61

INSTEAD OF

Dec. 29, 1898 62 yrs.

72 yrs.

Dec. 29, 1888

ITEM NO. SHOULD READ

8 & 9 Dec. 29, 1888

DOCUMENT Welfare Records.

BY AFFIDAVIT OF Funeral Home

G. Montgomery 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 Thomas A. Shea

Licensed Embalmer No. 4954

P. O. Address K.C. Mo.

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.