

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002462

WRITE
TUB AMENDED

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 4

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>Lebanon</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>Louise G. Wallace Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>160 Cresteline</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Elizabeth Kinkade</u>			4. DATE OF DEATH Month Day Year <u>Jan. 4, 1962</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</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>7-11-82</u>
9. AGE (last birthday) <u>79</u>		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) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Wright Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13a. FATHER'S NAME <u>William Hughes</u>	
13b. MOTHER'S MAIDEN NAME <u>Eliza J. Lowrance</u>		14. NAME OF HUSBAND OR WIFE <u>deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs. H. C. Bledsoe, Rt. 5, Lebanon, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia, bilateral</u> 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			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
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 <u>July 1941</u> to <u>Jan, 4, 1962</u> and last saw her <u>Jan, 4, 1962</u> alive on <u>Jan, 4, 1962</u> Death occurred at <u>9:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James L. Hope, M.D.</u>		22b. ADDRESS <u>158 N. Adams, Lebanon, Mo.</u>	22c. DATE SIGNED <u>6-4-1962</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1-5-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lebanon, Laclede Co. Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>J. Shadel Lebanon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-5-1962</u>	26. REGISTRAR'S SIGNATURE <u>Mella L. Day</u>

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

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FEB 7 1962

STATEMENT BY LICENSED EMBALMER

I hereby cer

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

working under my _____, Student Embalmer No. _____

Student _____ my personal supervision.

Signature of Student Embalmer

Signed Bice M. Abbott

Licensed Embalmer No. 5115

P. O. Address Springfield, Mo.

Note: The _____ with the above cons _____ If embalmed _____ If this body _____
The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply constitutes grounds for revocation of license).
If signed by a STUDENT, he also shall sign in his OWN handwriting.
If the body is not embalmed, fact should be so stated above.