

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005123

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 333 Primary Registration District No. 6114 Registrar's No. 2

FILED JAN 8 1962

1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Scott</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MORLEY</u>		Length of stay in 1b <u>6 YRS.</u>		c. CITY OR TOWN <u>MORLEY</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				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>Z.</u> Last <u>KINDRED</u>			4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1962</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-17-1913</u>	9. AGE (last birthday) <u>48</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>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) <u>St. Louis</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WALTER Schott</u>			13b. MOTHER'S MAIDEN NAME <u>VICTORIA A KRUMM</u>		14. NAME OF HUSBAND OR WIFE <u>W.W. "Bill" Kindred</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>W.W. Kindred Sikeston 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>Coronary occlusion</u> DUE TO (b) <u>Obesity</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension. Secondary anemia.</u>					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		
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 <u>12-16-61</u> to <u>1-3-62</u> and last saw her ^{her} _{him} alive on <u>1-2-62</u> Death occurred at <u>6:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>E.D. Urban, M.D.</u>				22b. ADDRESS <u>Sikeston</u>		22c. DATE SIGNED <u>1-3-62</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	23b. DATE <u>1-6-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MORLEY CEMETERY</u>		23d. LOCATION (City, town, or county) <u>MORLEY</u>		STATE <u>MO</u>	
24. FUNERAL DIRECTOR <u>Wells Funeral Home Sikeston Mo.</u>			ADDRESS <u>Sikeston Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan-3-1962</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT MEDICAL CERTIFICATION SHOULD READ BY AFFIDAVIT OF

JAN 12 1962

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

Permit issued

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.