

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-031681

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AUG 28 1962

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 179 Primary Registration District No. 4287 Registrar's No. 122

FILED SEP 10 1962

1. PLACE OF DEATH a. COUNTY <u>LINCOLN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LINCOLN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>TROY</u>		c. CITY OR TOWN <u>Winfield</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SUNSET RET. HOME</u>		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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) First <u>MARY</u> Middle <u>ELIZA</u> Last <u>KINSEY</u>			4. DATE OF DEATH Month <u>AUG.</u> Day <u>28</u> Year <u>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>AUG. 1872</u>	9. AGE (last birthday) <u>90-</u>	IF UNDER 1 YEAR 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>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>STURGEON, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JOHN HOPPER</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>GEO. E. KINSEY</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. <u>NONE</u>	17. INFORMANT <u>CHARLES HOBBS - Winfield, 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 heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
DUE TO (b) <u>Infirmities of age</u>		
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

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.	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>May 1959</u> to <u>Aug 28 62</u> and last saw her/him alive on <u>Aug 26 62</u> Death occurred at <u>3:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge from the causes stated.		22c. DATE SIGNED <u>Aug 30 62</u>	
22a. SIGNATURE <u>H. F. Kelly</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Troy Mo.</u>	22c. DATE SIGNED (date)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8/30/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW SALEM</u>	23d. LOCATION (City, town, or county) <u>WRFD - WINFIELD, Mo.</u>
24. FUNERAL DIRECTOR <u>O. C. RICKS</u> ADDRESS <u>ELSBERG, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-5-62</u>	26. REGISTRAR'S SIGNATURE <u>Charlotte Beck</u>

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
 10570
 20570
 3
 4 1
 5 2
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 7 0
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 94201
 10
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 12 86-2
 13 1-0
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 USE BLACK INK OR TYPEWRITER RIBBON

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 *W. J. ...*

Licensed Embalmer No. 4012

P. O. Address _____

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 STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.