

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0026099

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

JUL 28 1964

Registration District No. 31647 Primary Registration District No. 3008

Registrar's No. 188

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0147

2 3008

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>20 yrs.</u>	c. CITY OR TOWN <u>Kansas City</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>Fulton State Hosp. & Mental Inst.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>unknown</u>		
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Pinkard</u> Last <u>Pinkard</u>			4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>64</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25, 1920</u>	9. AGE (last birthday) <u>44</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>Laborer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>United States of America</u>	
13a. FATHER'S NAME <u>Andrew Pinkard</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>STATE HOSPITAL No. 1, Fulton, 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>Cerebral Thrombosis</u>						
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						
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>20 July 64</u> to <u>20 July 64</u> and last saw ^{her} him alive on <u>20 July 64</u> Death occurred at <u>7:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Dr. Henry Nathaniel De...</u>			22b. ADDRESS <u>Fulton State Hospital</u>		22c. DATE SIGNED <u>20 July 64</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7-28-64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		23d. LOCATION (City, town, or county) <u>Columbia</u>	STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Robert J. Shuster</u>			ADDRESS <u>Columbia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>July 28 - 1964</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

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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 _____

Licensed Embalmer No. _____

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 a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.