V. S. No. 2
30M—5-42
Rev. 5-17-39
I X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

11270

State File No.

FILED APR 14 1943

Registration District No. 314 Primary Registration District No. 6062 Registrar's No.

1. PLACE OF DEATH:

(a) County St Clair

(b) City or town Vista Rural (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 (Specify whether In this community 46 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Clair

(c) City or town Vista Rural (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William Kincaid

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife Sallie L Kincaid

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 8 (Month) 2 (Day) 1861 (Year)

8. AGE: Years 81 Months 5 Days 8 If less than one day hr. min.

9. Birthplace Eaton (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Finley Kincaid
13. Birthplace (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Margaret Pence
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Jake Kincaid

(b) Address Osceola Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-43 (Month) (Day) (Year)

(c) Place: burial or cremation Maddox

18. (a) Signature of funeral director Osceola Funeral Home

(b) Address Osceola Mo

19. (a) 3-16-43 (Date received local registrar) (b) F B Goodwin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10 year 1943 hour 12 minute Noon M.

21. I hereby certify that I attended the deceased from 5-4- 1943, to 1-10 1943; that I last saw him alive on 10-6- 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Cerebral Hemorrhage	4 mos
Due to Hypertension	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

83a

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature T. H. Douglas, Jr. (M. D. or other) M.D.

Address Osceola, Mo. Date signed 3-16-43.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 3-43-49
Date Filed 4-6-43

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Chas. Gilbert Hathaway

Licensed Embalmer No. 4267

P. O. Address Osceola, 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 this body is not embalmed, fact should be so stated above.