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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF REGISTRATION  
1947  
FILED JAN 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1389  
92

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 3228 Park /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 63 years \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3228 Park 8  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country No

3. (a) PRINT FULL NAME CARRIE VINCENT  
3. (b) If veteran, name war no  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 6  
year 1947 hour 9 minute 30 P.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Jas A. Vincent Deceased  
6. (c) Age of husband or wife if Deceased years  
7. Birth date of deceased September 5 1859  
(Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
87 4 1 hr. \_\_\_\_\_ /min.

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above  
Immediate cause of death Deputy Coroner Coronary Sclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace New York  
(City, town, or county) (State or foreign country)  
10. Usual occupation Home  
11. Industry or business X

Other conditions (Include pregnancy within 3 months of death) 93 d  
Major findings: Of operations \_\_\_\_\_  
Of autopsy History of inspection

MOTHER FATHER  
12. Name " Holmes 9  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name " Stiles  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Mrs. Grace Peuter  
(b) Address 3228 Park K. C. 3 Mo  
17. (a) Burial (b) Date thereof Jan 8 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Washington Cemetery  
18. (a) Signature of funeral director Wilks Funeral Home  
(b) Address 2315 Linwood K. C. 3 Mo  
19. (a) 1-8-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

23. Signature A.E. Wiser (M. D. or other) MD  
Address 2800 Main Date signed 1/9/47

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

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Chas E Welks

Licensed Embalmer No. 2644

P. O. Address 17. C. 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.**