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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1944

Registration District No. 7987

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3459

Primary Registration District No. 3040

Registrar's No. 12

1. PLACE OF DEATH:
(a) County Livingston
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
749 Graves Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 46 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri. (b) County Livingston
(c) City or town 749 Graves Street
(If outside city or town limits, write "RURAL")
(d) Street No. Chillicothe
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Francis M. Kincaid
3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 29 (Day) 1897 (Year)

8. AGE: Years 46 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Trenton, (City, town, or county) Missouri. (State or foreign country)
10. Usual occupation At Home
11. Industry or business

MOTHER FATHER
12. Name George W. Kincaid
13. Birthplace Missouri. (City, town, or county) (State or foreign country)
14. Maiden name Odey Johnson
15. Birthplace Missouri. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs George W. Kincaid
(b) Address Chillicothe, Missouri.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-'44 (Month) (Day) (Year)
(c) Place: burial or cremation Forrest Park Cemetery
18. (a) Signature of funeral director F. B. Norman Co.
(b) Address Chillicothe, Missouri.
19. (a) January 27 (Date received local registrar) (b) Lou Ella Cox-7 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22nd.
year 1944 hour 9:45 minute A: M.
21. I hereby certify that I attended the deceased from Jan. 15, 1944, to Jan. 22, 1944, that I last saw him alive on Jan. 21, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis	
Due to	
Due to	
Other conditions. (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 H. S. Powell (M. D. or other)
Address Chillicothe Mo Date signed 1-24-44

458 (Licensed Embalmer's Statement on Reverse Side)

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.....

E. R. Norman ....., Registered Apprentice No.....,

working under my personal supervision.

Signed E R Norman

Licensed Embalmer No. 2374

P. O. Address Chillicothe, Missouri.

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.