

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **Alexian Brothers Hospital.**) File No. **38544**
 Registered No. **11165** St. _____ Ward _____

2. FULL NAME **William Kane, Sr.**
 (a) Residence. No. **737 Erskine Ave.** St. **24** Ward. **St. Louis Co. Mo**
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF (or) WIFE OF **Gatherine Kane**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 32nd, 1963.**

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
64	10	23	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Day Laborer**
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

10. NAME OF FATHER **Wm. Kane**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

14. INFORMANT **Mrs. Clara F. Stone**
 (Address) **737 Erskine Ave. St. L. Co.**

15. FILED **NOV 16 1928** **May C. Stanton**
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov. 14th. 1928**

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ **12. noon a.m.**

(THE CAUSE OF DEATH WAS AS FOLLOWS:
Pneumonia
followed by shock & injuries (fractured ribs)
due to falling from a refrigerating car
Accident

18. WHERE WAS DISEASE CONTRACTED **156th 1928 B**
 IF NOT AT PLACE OF DEATH: _____

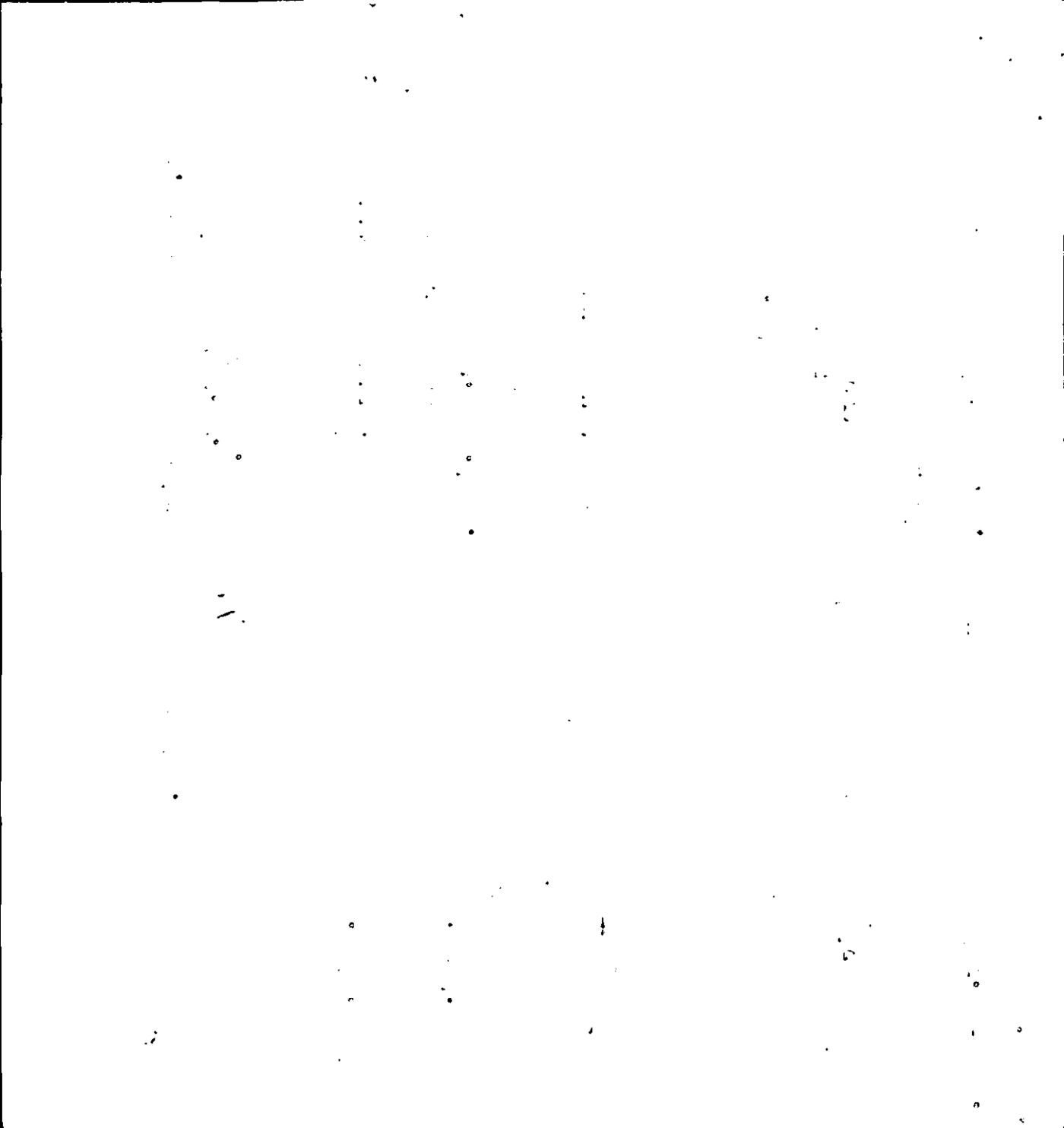
19. DID AN OPERATION PRECEDE DEATH? **108** DATE OF _____
 WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **J. W. Keme**
11/15, 1928 (Address) **Coroners Office**

*State the DEATH CAUSING DISEASE or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

20. PLACE OF BURIAL, CREMATION, OR REMOVAL **Calvary Cemetery** **DATE OF BURIAL** **Nov. 17 - 19 28.**

21. UNDERTAKER **Wacker-Heldens** **ADDRESS** **2331 S. Bdway.**



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 991 File No.
 Township..... Primary Registration District No. 1003 Registered No. 11165
 City St. Louis (No.) St. Ward.

2. FULL NAME William Kane Sr.
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address) St. Louis

15. FILED JAN 21 1919 W. E. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 14 1928

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... at..... on..... 19..... and that death occurred, on the date stated above, at..... in.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
following shock & injuries
due to falling from
refrigerator car
at accident
 CONTRIBUTORY (SECONDARY) Thy Mania a Watchman
of the Refrigerator Car Co. and
stumbled over a steel
rail in Building

18. WHERE WAS DISEASE CONTRACTED? St. Louis
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF OPERATION.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? 185
 (Signed) J. W. Kemmer M.D.
425 79th St. St. Louis (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-38544