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

Do not use this space.

8668

1. PLACE OF DEATH

County..... Registration District No. 791 1003

Township..... Primary Registration District No.....

City St Louis (No. City Hospital ..... St. ..... Ward)

File No.....

Registered No. 2341

2. FULL NAME Laurence Cain

(a) Residence. No. 7110 Cauldstream St., 4 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

12440

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 9 - 1891

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	37	8	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teamster
(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) Missouri

PARENTS

10. NAME OF FATHER James Cain

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

12. MAIDEN NAME OF MOTHER Elizabeth Grady

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

14. INFORMANT Edward Sheridan
(Address) City Hospital

15. FEB 20 1929 Filed, 19..... Noah C. Stevens
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 22 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 19..., to Feb 20, 19..., that I last saw h. alive on Feb 22, 1929, and that death occurred, on the date stated above, at 12:40 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia
followed by lung abscess
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Lung abscess non Tubercular
from Lobar Pneumonia (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? ..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) Edmund R. Sheridan M. D.
Feb 20, 19 29 (Address) City Hospital

*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
Calvary Cemetery	Feb 22 1929
20. UNDERTAKER	ADDRESS
Wm Ambruster	4234 Manchester

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Cain