

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

Do not use this space.

18166
2211

1. PLACE OF DEATH

County Jackson
Township Travo.
City K. C. (No. 2929 Campbell)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Aaron Devott Cain

(a) Residence. No. 2929 Campbell 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 | 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) Jan. 8 - 1893

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, _____ hrs. or _____ min.
45 | 11 | 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Russell Grain Co.
(b) General nature of industry, business, or establishment in which employed (or employer) Clerk.
(c) Name of employer _____

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

10. NAME OF FATHER Jno. Jacob. Cain

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

12. MAIDEN NAME OF MOTHER Mary J. Fry

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

14. INFORMANT J. A. Cain
(Address) 7400 Blue

15. FILED 5/14, 1929 M. M. Crowe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/12 1929

17. Deputy Coroner
I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Dilatation Heart
1120 1182 95E
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Acute Ischemic
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Staley M. Hall, M. D.
5/12, 1929 (Address) Deputy Coroner

*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 Stanherry Mo. DATE OF BURIAL 5/15 1929

20. UNDERTAKER Phillip's Undertaker Co ADDRESS Stanherry Mo.

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.

DEPARTMENT RECORD

2533

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