WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

6748

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 1575

City St Louis (No. En route City Hospital #1 St. ..... Ward)

2. FULL NAME David C Kindig

(a) Residence. No. 3154 Easton Ave St., 21 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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 2-1864

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	65	2	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Confectionary Store

(b) General nature of industry, business, or establishment in which employed (or employer) owner

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Benjamin Kindig

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

12. MAIDEN NAME OF MOTHER Hannah Coy

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

14. INFORMANT Elizabeth Kindig (Address) 3154 Easton Ave

15. FILED FEB 14 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 12 1930

17. No Physician In Attendance

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 6:20 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gunshot Wound of Chest caused by bullets fired from gun

173 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Homicide

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

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

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature] M. D.

2/13, 1930 (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	DATE OF BURIAL
Calvary Cemetery	2/15 1930

20. UNDERTAKER	ADDRESS
Arthur J Donnelly	2039 Wash St

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Coroners Off.