

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 791

Primary Registration District No. _____

Registrar's No. 9999

1. PLACE OF DEATH: 1008

(a) County 1

(b) City or town St. Louis

(c) Name of hospital or institution: St. Anthony's Hospital

(d) Length of stay: In hospital or institution 3 mos

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County _____

(c) City or town St. Louis

(d) Street No. 2005 So Grand

(e) If foreign born, how long in U. S. A. _____ years

8. (a) PRINT FULL NAME William J. Cain 5m

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 3, 1867

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 22nd day 22nd year 1939 hour One minute 10 to 70 M.

21. I hereby certify that I attended the deceased from Sept. 5, 1939 to Nov. 22, 1939, that I last saw him alive on November 22, 1939, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>19</u>		hr. _____ min. _____

9. Birthplace Ireland

10. Usual occupation Retired Sp. Adg. GDRR

11. Industry or business RR

12. Name John Cain 5

13. Birthplace Ireland 4

14. Maiden name Honora Johnston

15. Birthplace England

Immediate cause of death Cerebral Hemorrhage

Brucellosis

Due to _____

Due to _____

Other conditions _____

Major findings: Of operations

Of autopsy _____

Duration 17 hrs. 20/100

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant's own signature Helen Cain

(b) Address 2005 So Grand

17. (a) removal (b) Date thereof 11-22-39

(c) Place: burial or cremation Chicago Ill

18. (a) Signature of funeral director Lee B. Broun

(b) Address 3029 Caladere Ave

19. NOV 22 1939 (Date received local registrar)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence None

(c) Where did injury occur? None

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. L. Paine M.D. (M. D. or other)

Address 3720 Washington Bldg. Date signed 11-22-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Frank J. Swann

Licensed Embalmer No. 2245

P. O. Address St. James St.

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, above space should be left blank.