DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9737
1171

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days (Specify whether years, months or days)

In this community 4 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
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(d) Street No. 1025 Cherry
(If rural, give location)

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

3. (a) PRINT FULL NAME: Albert Joseph Kain 5th

3. (b) If veteran, name war: -

3. (c) Social Security No. No

4. Sex: male

5. Color or race: white

6. (a) Single, widowed, married, divorced: Div.

6. (b) Name of husband or wife: unknown

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

7. Birth date of deceased: July (Month) 26th (Day) 1894 (Year)

8. AGE: Years 45 Months 7 Days 14 If less than one day ____ hr. ____ min.

9. Birthplace: Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation: Entertainer ~~in~~

11. Industry or business: Ohio

FATHER
12. Name: Patrick Kain
13. Birthplace: Ohio
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Joanna Hennessey
15. Birthplace: Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Record clerk
(b) Address: K.C. General Hospital, K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: Thos. E. Funk
(b) Address: 2 E 9th

19. (a) Mch 15, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11th year 1940 hour 12 minute 05 P. M.

21. I hereby certify that I attended the deceased from 2-20-40, 19__, to 3-11-40, 19__; that I last saw him alive on 3-11-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary tuberculosis and cardiac decompensation	
Due to: 23	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: E. F. DeMaria M.D. (M. D. or other)
Address: Supt. K.C. Gen. Hospital, K.C. Mo. Date signed:

(Licensed Embalmer's Statement on Reverse Side)

Rev. 8-1739
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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 Thomas E. Turk

Licensed Embalmer No. 3776

P. O. Address R. C. Mo

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.