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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30214**
Registrar's No. **7491**

Registration District No. **791** Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4416 Chouteau
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether 0)
In this community 2
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")
(d) Street No. 4416 Chouteau
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME John W. Cain
3. (b) If veteran, name war None 3. (c) Social Security No. None
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Emma Cain 6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased Nov. 28, 1865
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 5
year 1940 hour 10.25 A.M. minute _____ M.
21. I hereby certify that I attended the deceased from Sept 1, 1940 to Sept 5, 1940
that last saw him alive on Aug 19, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
74 9 7 hr. _____ min.

Immediate cause of death Arteriosclerosis
Due to _____
Due to _____
Other conditions Asphyxy
(Include pregnancy within 3 months of death)

9. Birthplace Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Mail Carrier
11. Industry or business _____
12. Name Jacob Cain
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
16. (a) Informant Emma C. Cain
(b) Address 4416 Chouteau
17. (a) Burial (b) Date thereof 9/7/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Lebanon Cemetery
Edith E. Ambruster
18. (a) Signature of funeral director Edith E. Ambruster
(b) Address 4234 Manchester
19. (a) SEP 6 1940 (b) J.P. Prodeck
(Date received local registrar) (Registrar's signature)

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?
While at work? _____ (Specify type of place) (e) Means of injury _____
Signature M. Ed. Kette (M. D. or other)
Address 4234 Manchester Date signed 9/5/40

STATEMENT BY LICENSED EMBALMER

9

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

Flora Eynck

Licensed Embalmer No.

1284

P. O. Address

St Louis 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, fact should be so stated above.