

JUL 20 1942

Registration District No. **863**

Primary Registration District No. **6137**

Registrar's No. **28**

1. PLACE OF DEATH:

(a) County TEXAS

(b) City or town HOUSTON PINEY

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....

In this community..... 6 YRS (Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN AUSTIN CAIN

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex MALE **5. Color or race** WHITE

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

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

7. Birth date of deceased FEB. 14 1853
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>7</u>	<u>25</u>	_____hr. _____min.

9. Birthplace IND. I
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

12. Name JOHN CAIN

13. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant PHILLIP CAIN

(b) Address HOUSTON, MO

17. (a) BURIAL (Burial, cremation, or removal) **(b) Date thereof** 10/19/41
(Month) (Day) (Year)

(c) Place: burial or cremation HOUSTON

18. (a) Signature of funeral director Hayward V. Elliott

(b) Address HOUSTON, MO

19. (a) _____ **(b)** _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County TEXAS 107

(c) City or town HOUSTON 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 9
year 1941 hour 1 minute A.M.

21. I hereby certify that I attended the deceased from AUG 1939 1939 to OCT 9 1941
that I last saw him alive on OCT 1 1941
and that death occurred on the date and hour stated above.

Immediate cause of death ACUTE BRONCHITIS OF UNKNOWN ETIOLOGY

Due to _____

Due to _____

Other conditions SENILITY
(Include pregnancy within 3 months of death)

Major findings: 1060

Of operations _____

Of autopsy _____

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? _____

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

23. Signature J. M. Dillman (M. D. or other) MO

Address HOUSTON, MO **Date signed** 10-11

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

MOTHER FATHER

RECEIVED
District Health Officer No. 5,
District File Number 241279
Date Filed 7-17-48

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.....

THIS BODY WAS NOT EMBALMED, Registered Apprentice No.

working under my personal supervision.

Signed Frank E. Wood

Licensed Embalmer No. 4026

P.O. Address Houston, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22472

Registration District No. 863

Primary Registration District No. 6137

Registrar's No.

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 6 yrs
years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

John Austin Cain

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Feb 14
(Month) (Day) (Year)

8. AGE: Years 88 Months 7 Days 14
If less than one day min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Oct. 9, 1941 (b) Mabel Shacklett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
19.....
that I have seen him/her alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

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?

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

S-22472