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M-5-43
5-17-35
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **22243**
9422
Registrar's No. _____

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1.0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
17

(c) City or town **St. Louis** **926**
(If outside city or town limits, write "RURAL")

(d) Street No. **2029a Bremen Avenue.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **John Patrick Kane**

3. (b) If veteran, name war **None**

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **23**
year **1943** hour **5** minute **180** M.

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **June 4 1886**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug 17 1943** to **Oct 23 1943**
that I last saw **him** alive on **Oct 23 1943**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

57 4 19 hr. min.

Immediate cause of death **Pulmonary Tuberculosis**
Duration **8-19-43**

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Maintenance Man**

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

11. Industry or business _____

12. Name **John Kane**

13. Birthplace **Unknown Ireland 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Murphy**

15. Birthplace **Unknown Ireland 4**
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

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

16. (a) Informant **Mrs. Bertha Kane**

(b) Address **2029a Bremen Avenue.**

17. (a) **Burial** (b) Date thereof **10/27/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

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? _____

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**

(b) Address **4700 Washington Blvd.**

19. (a) **OCT 26 1943** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature **W. E. ...** (M. D. or other) **W. E.**
Address **380 2nd Street** Date signed **10-25-43**

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

Robert G. Koffa

Licensed Embalmer No..... *2971*

P. O. Address.....

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.