

FILED JUN 9 1944

1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 4964

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1422 N. Taylor Ave. /
(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 Mo. (b) County 000
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1422 N. Taylor Ave.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
 year 1944 hour 3 minute _____ A. M.
 21. I hereby certify that I attended the deceased from 1938
 _____, 19____, to death 5-29-44
 that I last saw him alive on Feb 1, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary atherosclerosis Duration 4 yrs
 Due to arteriosclerosis 9 yrs
 Due to hypertension 9 yrs
 Other conditions: arteriosclerosis
(Include emergency within 3 months of death)
 Major findings: arteriosclerosis
 Of operation: 30 9/4
 Of autopsy: _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Dr. Edward B. Kinder
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Eleanor Kinder 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Mar. 10 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>2</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation Physician

11. Industry or business _____

MOTHER FATHER { 12. Name Andrew Kinder
 13. Birthplace Unknown (City, town, or county) (State or foreign country)
 14. Maiden name Sarah Drumm
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Eva Kinder
 (b) Address 1422 N. Taylor Ave.

17. (a) Removal (b) Date thereof 5-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jackson Mo.

18. (a) Signature of funeral director Drehmann-Harrel

(b) Address 1905 Union Blvd.

19. (a) MAY 30 1944 (b) J. F. Budick
(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?
(Specify type of plane)
 While at work? _____ (e) Means of injury _____

23. Signature: Kent S. Nelson (M. D. or other) MD
 Address 4952 Maryland Date signed 5-29-44

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

Motoy

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.....

Albert A. Thompson

Licensed Embalmer No.....

4237

P. O. Address.....

St. Louis

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.