

S. No. 2
M-5-42
7-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12452
Registrar's No. 1975

Registration District No. 149

Primary Registration District No. 1002

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: **Trinity Lutheran Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days** (Specify whether
In this community **25 years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3930 Troost** (If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **3**
year **45** hour **4** minute **30 A.M.**
21. I hereby certify that I attended the deceased from **April 28**
1945 to **May 3** 19**45**
that I last saw him alive on **May 3** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Bronchial Pneumonia** Duration **3 day**
Due to: **Senilis & fatigue**
Due to:
Other conditions: **Chronic Nephritis** **sterility**
(Include pregnancy within 3 months of death)
Major findings:
Of operations: **13/15**
Of autopsy:
PHYSICIAN
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **Robert Morton Saint**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Widower**
(b) Name of husband or wife **Battle Lois Saint** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **June 10, 1860**
(Month) (Day) (Year)

8. AGE: Years **85 84** Months **10** Days **23** If less than one day hr. min.

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

10. Usual occupation **Photo Engraver**

11. Industry or business **retired**

MOTHER FATHER
12. Name **John J. Saint**
13. Birthplace **No Record** (City, town, or county) (State or foreign country)
14. Maiden name **No Record**
15. Birthplace **No Record** (City, town, or county) (State or foreign country)

16. (a) Informant **Fred H. Saint**
(b) Address **Fort Wayne Indiana**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **50-4-45** (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Moriah Cemetery**

18. (a) Signature of funeral director **Thos. A. Muirk**
(b) Address **4316 Troost Ave**

19. (a) **5-4-45** (Date received local registrar) (b) **Sheldine Holmes** (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) (c) Means of injury **0**
23. Signature **J. J. Gravello M.D.** (M. D. or other)
Address **3706 Broadway, Kansas City, Mo** Date signed **5/3-45**

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

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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. Linnick

Licensed Embalmer No.....

3775

P. O. Address.....

P. O. Md

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.