

X35697

JUN 30 1945 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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Park Lane Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 weeks
(Specify whether years, months or days)
In this community 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 9 10
(d) Street No. 4016a Pleasant Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME PEARL M. KINCAID

3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced, Widow

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

7. Birth date of deceased Feb. 23, 1894
(Month) (Day) (Year)

8. AGE: Years 51 Months 3 Days 20
If less than one day hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

12. Name John Collis

13. Birthplace Georgia /
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Georgia /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ray Coleman

(b) Address 4018a Pleasant Street

17. (a) Burial (b) Date thereof 6/15/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Math. Hermann & Son

(b) Address 2161 East Fair Avenue

19. (a) JUN 14 1945 J. P. Braden
(Date registered) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12
year 1945 hour 8 minute 10 PM.

21. I hereby certify that I attended the deceased from 5-4
1945 to 6-12 19 45

that I last saw her alive on 6-12 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cerebral Hemorrhage
multiple
Due to Cerebral Secrecion, Chy
& interstitial nephritis

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

Major findings: Of operations _____

Of autopsy _____

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) Means of injury _____

23. Signature J. P. Braden (M. D. or other) _____

Address 4930 Lindell Date signed 6-12-45

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 William G. Buchholz

Licensed Embalmer No. 21102

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.