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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 3 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 619

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: Homer G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 Mins. (Specify whether years, months or days)

In this community

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")

(d) Street No. 2118a O'Fallon 9 21
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sandie Kincaid

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 3

5. Color or race Negro

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

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

7. Birth date of deceased 6 (Month) 28 (Day) 45 (Year)

8. AGE: Years | Months | Days | If less than one day, hr. 24 min.

9. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Aaron Kincaid
13. Birthplace Yazoo City Mississippi 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Willie Mae Moore
15. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Mary T. Duvall
(b) Address 2601 N. Whittier Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof JUL 26 1945 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director T. B. Hudson
(b) Address City Health Dept

19. (a) JUL 25 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 28 year 1945 hour 1 minute 00 P.M.

21. I hereby certify that I attended the deceased from 12:36 P. M. 6 - 28, 1945 to 1:00 P.M. 6-28, 1945 that I last saw her alive on 6 - 28, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Newborn	
Due to: Congenital Atelectasis	
Due to:	
Other conditions (Includes pregnancy within 3 months of death): 161a	
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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature W. J. Sinkler (M. D. or other) XXXXX

Address 2601 N. Whittier Date signed 7-12-

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.