

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29133

State File No.

FILED 00318 1945
Registration District No.

Primary Registration District No. 1003

Registrar's No. 8384

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-Max C. Starkloff
(If not in hospital or institution, write street number or location) Memorial
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community 67 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17
(d) Street No. 102 So. 4th St. 925
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME GEORGE KANE

3. (b) If veteran, name war unk. 3. (c) Social Security No. unk.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased March 7th, 1878
(Month) (Day) (Year)

8. AGE: abt 77 Years Months Days If less than one day
hr. min.

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

10. Usual occupation unk.

11. Industry or business

12. Name Issac Kane

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

14. Maiden name Martha unk.

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital
Anatomical Board

17. (a) Date of death SEP 27 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director J. Richter

(b) Address SEP 27 1945 3500 Kutler

19. (a) Date received local registrar (b) Registrar's signature J. F. Brebeck

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 20th
year 1945 hour 3:20 minute P. M.

21. I hereby certify that I attended the deceased from 9/16/45
....., 19....., to 9/20/45, 19.....;
that I last saw h im alive on 9/20/45, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease with failure
Duration

Due to 93 h
Due to

Other conditions cellulitis arm & leg
(Include pregnancy within 3 months of death)

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature B. W. D. Lafayette Date signed 9/20/45
Address.....

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

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.