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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U.S. GOVERNMENT PRINTING OFFICE: 1945
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31748**
Registration District No. **318**
Primary Registration District No. **1003**
Registrar's No. **9012**

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:
ENROUTE TO CITY HOSPITAL 3
(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

3. (a) PRINT FULL NAME CHARLES EDWARD CAINE
3. (b) If veteran, name war UNKNOWN
3. (c) Social Security No. UNKNOWN

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced DIVORCED
6. (b) Name of husband or wife UNKNOWN
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased AUGUST 8 1870
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 9
If less than one day _____ hr. _____ min.

9. Birthplace PERU INDIANA
(City, town, or county) (State or foreign country)
10. Usual occupation RETIRED HOTEL CLERK

11. Industry or business _____
12. Name GEORGE E. CAINE
13. Birthplace CLEVELAND OHIO
(City, town, or county) (State or foreign country)
14. Maiden name ANNA E. BUCK
15. Birthplace SANDY HILL NEW YORK
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. W. L. McBRIDE
(b) Address ROCKPORT TEXAS
17. (a) CREMATION (b) Date thereof 10-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation VAI HAINA CREMATORY

18. (a) Signature of funeral director ALBERT H. HOPPE
(b) Address 4700 WASHINGTON
19. (a) OCT. 18, 1945 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 25 MOO
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 707 1/2 6th STREET
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 17
year 1945 hour 6 minute 30 M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Coronary Sclerosis
Arteriosclerosis
Due to _____
Other conditions _____
(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)
Means of injury _____
23. Signature Dr. G. J. Perry (M. D. or other) _____
Address Rockport Date signed 10/18/45

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.....

Not embalmed....., 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.

Registration District No. 318 Primary Registration District No. 1003

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:
(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)

3. (a) PRINT FULL NAME Charles E. Caine
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex m
 5. Color or race w
 6. (a) Single, widowed, married, divorced Div
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive.....
 7. Birth date of deceased aug (Month) 2 (Day) 1945 (Year)

8. AGE: Years 75 Months 2 Days 2
If less than one day
 hr. min.

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

10. Usual occupation.....

MOTHER FATHER.
 11. Industry or business.....
 12. Name.....
 13. Birthplace.....
(City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....
 (b) Address.....

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

18. (a) Signature of funeral director.....
 (b) Address.....

19. (a) 10-18-1945 (b) G. F. Bredenk
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1945 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him/her alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....
 Due to.....
 Due to.....
 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)
 (e) Means of injury.....
 23. Signature..... (M. D. or other)
 Address..... Date signed.....

SUPPLEMENTARY

Duration.....
PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

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