S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 24 1947 318

Registration District No.

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 36137

Registrar's No. 9612

WRITE PLAINLY—USING 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: MO. BAPTIST HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 70 YRS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County — Good

(c) City or town ST LOUIS (If outside city or town limits, write "RURAL") 17

(d) Street No. 5423 MAPLE AVE. (If rural, give location) 9

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

If yes, name country —

3. (a) PRINT FULL NAME LINN PAINE

3. (b) If veteran, name war NO

3. (c) Social Security No.

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 APRIL-24-1870 (Month) (Day) (Year)

8. AGE: Years 77 Months 5 Days 21 If less than one day — hr. — min.

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

10. Usual occupation SALESMAN

11. Industry or business JEWELERY.

FATHER
12. Name LYMAN SWIFT PAINE
13. Birthplace ALBANY (City, town, or county) NEW YORK (State or foreign country)

MOTHER
14. Maiden name KATE MCLAUHLIN MILLER
15. Birthplace LEWISBURG (City, town, or county) PA. (State or foreign country)

16. (a) Informant Mrs J. Jarvis Lang

(b) Address 648 OAKWOOD AVE.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 17-1947 (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA CEM.

18. (a) Signature of funeral director Parker Und Co

(b) Address WEBSTER GROVES, MO.

19. (a) OCT 16 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15th year 1947 hour nine minute A. M.

21. I hereby certify that I attended the deceased from April 29, 1946, to October 15, 1947; that I last saw him alive on October 15, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Thrombosis	1 day
Due to Hypertension	1 year
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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PHYSICIAN

Underline the cause of 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 John Lane Kerr (M. D. ~~XXXX~~)

Address 508 N. Grand Blvd. Date signed 10/16/47

Jefferson City Printing Co.

(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 Leslie Nolch

Licensed Embalmer No. 4395

P. O. Address Webster Groves 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.