

FILED SEP 20 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

31153

7919

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County ST. LOUIS
 (b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Barnes Hospital, 0
(If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution 1 HOUR 40 MINUTES
(Specify whether FORTH HOSPITAL ADMISSION)
 In this community FOURTH HOSPITAL ADMISSION
years, months or days

2. USUAL RESIDENCE OF DECEASED:

MISSOURI
 (a) State MISSOURI (b) County 095
 (c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
4127 CHOUTEAU
 (d) Street No. 18 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

WILLIAM MATHEW KANE

3. (b) If veteran, name war

None

3. (c) Social Security No.

493-09-1249

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced 2

6. (b) Name of husband or wife Grace

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Mar. 24 1910
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	38	5	13	hr. min.

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

10. Usual occupation Foreman

11. Industry or business Big Bend Lumber Co.

MOTHER FATHER

12. Name William J. Kane

13. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Ida Ikemeier

15. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Teresa Bauer

(b) Address 1407 Grant Rd.

17. (a) Burial (b) Date thereof 9-10-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cem.

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

(b) Address 4228 S. Kingshighway Bl.

19. (a) SEP 9 1948 (b) J. F. Br...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER, 7
 year 1948 hour 6 minute 10 p. M.

21. I hereby certify that I attended the deceased from MAY, 1947, to SEPTEMBER 7, 1948

that I last saw him alive on SEPTEMBER 7, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death

CACHEXIA

Due to HODGKINS' DISEASE AND TUBERCULOSIS

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy As above

Duration

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 0

23. Signature Lawrence W. O'Neil (M. D. or other) MD.
 Address Barnes Hospital - D-0-N-248

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... *Edwin M. Deery*

Licensed Embalmer No... *3024*

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.